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Thesis Approval

This is to certify that the thesis presented to us by Abby Corinne Calisch on the 21st day of April, 1976, in partial fulfillment of the requirements for the degree of Master of Science has been examined and is acceptable in both scholarship and literary quality.

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A COMPARATIVE STUDY OF THE DEFENSE OF ISOLATION AS IT APPEARS IN THE ART PRODUCTIONS OF SCHIZOPHRENICS AND ALCOHOL DEPENDENTS

A Thesis Presented to the Faculty of the Graduate School of the Hahnemann Medical College in Partial Fulfillment of the Requirements for the Degree of

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by

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ABSTRACT

This paper examines the defense of isolation in comparing the art productions of alcoholic and schizophrenic patients in art therapy. Raters with varied training and experience in art therapy evaluated twenty sets of art productions using a rating scale that attempted to quantify basic defensive structures as related to diagnostic categories of psychopathology.

The results of this study indicate that there are noticeable psychopathological characteristics of the defense of isolation present in all art productions represented, according to subdivisions including Ego disturbance, conflict and anxiety, reality orientation, and organicity. Differences and similarities between the scores of population groups represented are analyzed and implications drawn.

The results have particular import in the treatment of alcoholism at the mental health institutes because alcoholics have traditionally received treatment geared to the arrest of the alcoholic symptomatology and have not been treated for underlying problems which may exist. This study serves to validate the concept that alcoholism manifests as a symptom of psychopathology, predominantly in the defense of isolation.

In addition, this study examines the concepts of Art Therapy and reiterates its validity and usefulness in diagnosis.

CHAPTER I

INTRODUCTION

It is a natural tendency for people to overindulge in the pleasures that society makes available. Abuse of alcohol is a noticeable problem both for the individual as well as their community. Because of similarities the author noticed in the art productions of alcoholic patients and schizophrenic patients in group settings, these two groups are compared. These similarities are dealt with in more detail in Chapter VI.

The literature makes mention of oral factors shared by both schizophrenics and alcoholics. Lawrence Kolb (1973), R. P. Knight (1975), and N. E. Chafetz (1953) relate alcohol dependence to trauma in the oral phase and describe it as an oral perversion.

Philip Soloman and Vernon Patch (1971) state that in schizophrenia, "there is a regression to the early oral (sucking) stage." This phase occurs while the principle focus of pleasure is in sucking.

The purpose of this paper is to examine the applicability of art productions as a dynamic tool in diagnosis using a quantifiable tool as a measure.

According to Levick (1969), Art Therapy is diagnostically useful to the differentiation of affective disorders, thought disorders, and organicity. She applies the principles of

interpretation of projective psychological tests to the understanding of artistic productions.

The primary goal of this paper is to examine the hypothesis: that there is no difference between the defense of isolation manifested in the artwork of alcoholics and that evidenced in the artwork of schizophrenics. The author further contends that art therapy raters will not be able to differentiate between the drawings of alcoholics and those of schizophrenic patients.

In the course of their study, many questions will be raised and examined: Will the groups differ; and how will they compare on specific criteria? What generalizations, if any can be formulated about these groups? What implications will these findings have on the therapeutic treatment of these groups? What quantifying measures will allow for standardizing of these diagnostic distinctions thus expediting appropriate treatment measures.

And, ultimately, what effects and applications would such an understanding and diagnostic differentiation offer to an appreciation of human behavior; and to the relationship of art and art therapy as a measure and tool to aid in diagnostic and therapeutic intervention?

CHAPTER II

LITERATURE REVIEW

Part 1: Literature Review of the Defense of Isolation

The subject of defense mechanisms has been the topic of psychoanalytic discussion since the term "defense" appeared in Sigmund Freud's paper "The Neuro-Psychoses of Defense" (1894). Continuing her father's work on defense mechanisms, Anna Freud (1946) defined "defense" as a general designation for all the techniques used by the ego in conflicts which may lead to neurosis. She further identified nine defense mechanisms: regression, repression, reaction-formation, isolation, undoing, projection, introjection, turning against the self, and reversal.

Robert Waelder (1960) reiterated the previously mentioned defenses with the exclusion of "turning against the self," and with the addition of the defense he called "displacement."

The most restrictive list of defenses was set forth by E. Sperling (1958). He omitted from A. Freud's list.... regression, reversal, displacement, and turning against the self. He condensed others into "simple unconscious forms of inhibition and avoidance, which A. Freud (1946) identified as constellations, using combinations of the nine mechanisms.

One of the longest lists of defenses originated with R. A. Spitz (1961). In addition to the nine defenses listed by A. Freud, Spitz listed denial, displacement, and intellectualization.

As observation and study of defenses warrants extensive research, the scope of this paper will be limited to the defense of isolation. This defense will be examined by definition, psychological function, and its appearance in various diagnoses.

In relation to psychological functions, isolation is termed both as a "healthy" and as a "maladaptive" defense. This seemingly divergent view of a defense mechanism was explained by E. S. Wallerstein (1967): "What determines whether a defense is normal or abnormal is its functional relevance; is whether it is predominantly in the service of control or of healthy adaptation."

A. Freud remarked that the mechanism of isolation can be described as:

> "An exaggeration of some aspects of adequate ideational process. The normal phenomenon of concentration provides a pretext for this kind of neurotic procedure: what seems to us important in the way of an impression or a piece of work must not be interfered with by the simultaneous claims of any other mental processes or activities. ---Thus in the normal cause of things, the ego has a great deal of isolating work to do in its function of directing the current of thought." (1966)

The function of isolation can be viewed in two major

categories: the internal defense and the defense in relation to external reality.

On examining this as an internal defense it appears to be directed at the instinctual drives. Instinctual drive energies are connected to unconscious sexual and aggressive pursuits. The function of the defense of isolation is one by which the instinctual impulses are removed from context, while retaining them in consciousness.

S. Freud described the function of isolation:

> "The censorship is directed only against the connection between two thoughts, which are objectionable separately. If so, the two thoughts will enter consciousness in succession; the connection between them will remain concealed, but instead a superficial link between them will occur to us, of which we should otherwise never have thought." (1900)

Coinciding with this view is K. R. Eissler's (1959) emphasis that processes of isolation always seem to go together with processes leading to the formation of "false" or "inadequate" gestalts of mental contents:

> "Thus, parallel with isolation, through which things belong together are unremittingly separated and kept apart, a countermovement is maintained whereby elements which do not belong together are firmly connected and kept together." (1959)

The defense of isolation is also directed against affects or feelings.

In 1946 Otto Fenichel drew up a list of defensive processes which he found to be used against painful affects.

Among others, the defense of isolation is mentioned. He stated, "Many defensive attitudes are not only directed against the situation in which anxiety may arise but against the appearance of the anxiety itself."

The duality of defensive functions was noted also by Anna Freud (1946), who stated, "Whenever the ego seeks to defend itself against instinctual impulses, it is obliged to ward off also the affects associated with the instinctual process."

Systems may also be targets of the defensive processes of isolation. According to psychoanalytic theory, the three structures of the personality are the id, the ego, and the superego. The id is the reservoir of all psychic energy from the instinctual drives. The ego serves as the regulator between the id and the external world. The superego is the seat of moral percepts and ideal aspirations.

The concept that the superego as a whole can be subjected to isolation from the ego was first proposed by Fenichel (1946).

> "Whereas ordinarily the ego endeavors to meet the requirements of the superego or occasionally takes steps to ward them off, here the ego appears to keep the superego actively and consistently at a distance."

The defense of isolation is also directed against symptoms when the symptoms are experienced as ego-alien, i.e., as entailing a loss of ego control over mental contents and behaviors.

Work done by S. Freud resulted in awareness that the symptom expresses the instinctual drive which is warded off, and then becomes a target for further defenses.

> "For the symptom, being the true substitute for and derivative of the repressed impulse, carries on the role of the latter continually renews its demand for satisfaction and thus obliges the ego in its turn to give the signal of unpleasure and put itself in a posture of defense." (1966)

Now that the symptom is formed the ego must deal with the symptom. The ego can either make an adaptation to this symptom or it "can assume complicated layers of symptoms in a defensive endeavor" (Sjoback 1973) for further isolation.

Hans Sjoback (1973) also stated that certain behaviors are caused solely by defensive processes. Of these types of behavior he lists certain types of inhibition, some phenomena caused by denial, and specific behaviors relating to variants of isolation.

Eissler (1959) stated that "in the isolation observed in obsessive-compulsive neurosis and obsessive-compulsive personalities the mechanism and the symptom coincide."

Wallerstein (1967) stated:

> "Defenses can range from discrete attributes or aspects explicable by reference to the simple operation of a single defense mechanism to complex behavioral and characterotogical constellations that are likewise specific, recurrent, and serve defensive purposes. These more complex configurations are variously called defensive operations and are made up of various combinations and sequences of behaviors, affects and ideas."

Much observation and study of isolation in conjunction with other defenses and with varied diagnoses has been written by Eissler (1959). He observes isolation in a triad with depersonalization and impulsiveness as well as the importance of isolation in character disorders and obsessive-compulsive disorders.

Eissler (1959) views isolation in the light of depersonalization.

> "The patient's depersonalization must be viewed under the aspect of the integrated principle of isolation. The reduction or disappearance of the patient's self concept in relation to personal affects, the environment, and interpersonal relations, is quantative view of isolation." (Eissler, 1959)

The isolation viewed by Eissler in the character disorder achieves its aim almost perfectly. If the patient with such a disorder did not have to "pay the price of a constant vague sense of pain or tension caused by his inability to experience pleasure, one might regard this type of psychopathology as a fortunate way out."

One last function of isolation was discussed by C. Rappaport (1960) relating to the hypothesis of defenses used against external reality.

> "In the first conception, the defense was directed against reality and the memory of real events. In the second conception, it was directed against the drive, and reality had only a peripheral role. In the third conception, reality and drives appear to gain an equal status."

In relation to this concept, isolation is viewed by Soloman and Patch (1971) in societal terms. "Isolation is the state of being excessively alone, by choice."

Marianne Eckardt (1960) also writes of the societal aspects of isolation.

> "The detached person is one who is not functioning, interacting as part of the life he is supposed to be part of, he seems to stand aside, look on and observe, but with the outlook of an outsider. Symptoms and offshoots of this attitude are viewed in the normal, the schizophrenic, and are part of the human story."

Rene Laforgue (1929) discussed both the social and internal aspects of isolation. He states that the process of isolation in schizophrenia simply represents one of the many possible choices (internal and external) of flight at the patient's disposal. The isolation often reveals special affective situations: the different affective tendencies of the subject arrive at a compromise along the line of self-punishment, masochism, or self-destruction.

The literature seems to show that the defense of isolation could be present in normal and pathological manners. It can be used as a defense against instinctual material and their representations and affects; and it may be used in conjunction with symptom formation. Thus it seems to be a major defense appearing in varied types

of diagnoses such as character disorders, obsessive-compulsive disorders, and schizophrenia. Isolation is a complex defense which cuts off the individual from internal and external functions.

Part II: Literature Review of Psychodynamics of Alcoholism

Alcoholism occurs when a person uses alcohol to supress some internal conflict or anxiety to the extent that this behavior interferes with their normal functioning. Alcoholism has been a problem studied by medical and psychiatric professionals for years. Recently this complex problem has become an interest to legal systems, sociologists, ethnographers, anthropologists, and economists alike.

The author has noticed in reading on the subject, a general trend leading away from provincial attitudes. However, no one explination of the nature of alcoholism has become solely accepted as valid.

Rather than conceptualizing alcoholism as a criminal or spiritual offense, the attitudes of today take an inclusive view. These attitudes recognize the importance of circumstantial elements such as environmental, family structure, and socio-economic factors.

The question of whether alcoholism is an illness or a symptom continues to go unresolved. A review of the literature will show that alcoholism is a multi-determined condition, however, the existence of underlying psychopathology will be evident. An attempt will be made to

reveal the similar functions of the defense of isolation and the act of drinking in alcoholism.

To first gain understanding of alcoholism one must study the literature in relation to the internal and external experiences of the alcoholic as well as the function of the behavior of drinking as seen by the experts in the field.

S. Freud (1930)and S. Rado (1953) were in agreement that changes in mood were the most valuable contribution of alcohol to the individual. Alcohol pharmacologically produced a magical sense of elation craved by the patient. Edward Griffith (1974), H. Kalant (1961), and William DeWitt (1952) also support the concept that alcohol is chosen for its pharmacological effects. Alcohol produces such effects as relaxation, lessening of inhibitions, numbing and ultimately, unconsciousness.

Richard Blum (1969) and A. A. Brill (1919) considered alcohol to be used for reductions of intimacy in relationships, escape from incestuous thoughts and homosexual impulses, as well as for pain reduction.

The background of the alcohol dependents were seen as significant factors by Karl Menninger (1938), P. F. Schilder (1941), and Ronald Cantanzaro (1968). The alcohol dependent was considered to be (self) destructive, stemming from a feeling of parental betrayal. Intense

insecurity was developed in parental associations which were usually rejecting, authoritarian, moralistic or success oriented. The child then substituted or displaced the insecurities at home onto the community at large, resulting in heightened social isolation and insufficiency. As a result, the alcohol dependent could not develop close ties, yet expected love, favor, and appreciation from others. Alcohol supplies for the alcohol dependent the feeling of being loved.

Alcohol provides a kind of universal therapy for the alcohol dependent state Soloman and Patch (1971) and Hoff (1961). Although the behavior is unconsciously motivated, it serves to maintain psychological equilibrium and to avoid disintegration. Alcohol serves such functions as building confidence, relieving anxiety, and suppressing guilt and anger.

Researchers such as Lawrence Kolb (1973), R. P. Knight (1975), and N. E. Chafetz (1953) suggest that alcohol dependence is an oral perversion resulting from trauma at a time when security and tension are achieved by oral stimulation. All agree that a character disorder is present, distinguished by demandingness, inability to express feelings or to carry out a sustained effort. Developmental arrests were noted in the growth of the ego and superego stemming from a fixed relationship with an

ambivalent maternal figure in the absence of a consistent father figure. Frustration is constantly evident and alcohol is used to pacify these tensions related to oral and sexual drives.

Some researchers such as Howard T. Blane (1970), E. M. Jellinek (1960), and Ronald Cantanzaro (1968) agree that alcohol dependency cannot be categorized in any standard classifications. They state that once given formal diagnosis, alcoholics tend to fall throughout the range of categories. Jellinek (1960) makes his own structural differentiation (alpha, beta, gamma) based upon the degree to which alcohol interferes with the daily life tasks. These researchers discuss alcohol dependents by shared characteristics such as: low frustration tolerance, immaturity, anxiety, grandiosity, isolation, guilt, and sex role confusion.

A psychological need for power was found to be an underlying problem with alcohol dependents by David McClelland, Davis, Kalin and Wanner (1972). They state that drinking may be directly related to fantasies of losing power over the self and is accompanied by a life history of gross disturbances in relationships, school, work, and marriage.

The psychopathology of the alcoholic was supported in the literature both by the symptom of excessive drinking and by the use of drinking behavior in blocking or isolating the emergence of painful material. The presence of the defense of isolation was evidenced by examining its single operation in alcoholism; and noting that it, like the symptom, is a recurrent behavioral pattern used specifically for warding off purposes. Although isolation appears in normal defense processes, in the case of the alcoholic the rigidity of the defense as well as the symptom are in the service or control of the conflict against healthy adaptation.

There is much room for study of the art productions of alcoholics. Such research would be valuable for many reasons, but the least of which is the possibility of noting and studying the patterns and characteristics of alcoholics' art productions which might give further credence to one or another theory of the etiology of alcoholism. The author was unable to find any studies in art therapy which dealt with the etiology of alcohol dependence as related to art productions.

Information was available however, on the importance

of art therapy with alcoholics. Both the definition and scope of art therapy are examined by Naumberg. "Analytically-oriented art therapy deals with the expression of the unconscious by means of projected images into graphic and plastic media." (1950) The artwork, as a means of non-verbal communication may be used with verbal associations of patients, and have the unique property of being concrete projections which may be reassociated to, or reviewed with, the patient.

Bellwood (1975) refers to the importance of art productions in working with alcoholics at Fort Logan Mental Health Center in Denver, Colorado. He states that over 60% of the alcoholics require some help with grief work due to real or fantasied losses. Although he does not define these terms within the context of his article, he states that depression, isolation, and anger are expressed by alcoholics in their artwork.

Forrest (1975) found art therapy to be of paramount importance in working with alcohol dependents. The alcoholic has great difficulty in identifying his feelings, due to the isolation and alienation he feels, both from the world and his own body, when drunk. The art disclosed graphically what the patient was feeling and also allowed the therapist to make the patient aware of his feelings.

Machover (1961) discussed the characteristics of the artwork of alcohol dependents. The unconscious motivation in the artwork seemed related to underlying defects of ego in the alcohol dependent, and a determined effort to compensate for defects. Low self-esteem was seen in the small size of figures drawn. The placement, relatively high on the paper, seemed often to correlate with lack of insight, low energy level, and, basically a sense of a lack of secure feeling. A thick line often appeared around objects as a barrier between self and the environment.

Part III: Literature Review of Normal and Psychotic Artwork

In the following pages, the author will attempt to summarize the most important theories and observations on normal and psychotic artwork from the vast amounts of literature on these subjects. This includes the relationship between artwork, dreamwork, manifest and latent content, and primary and secondary processes. The character of the artwork and its use in art therapy will also be noted.

As Janie Rhyne (1973) wrote, "All art productions are fantasies made real, and all convey a message."

Normal people use sublimation to create art or "symbolic expression of subconscious conflicts," stated

Reitman (1950). The subconscious is a motivating force which communicates to others. In contrast, in schizophrenics, the act of (artistic) creation is more of an acting out of artistic fantasies in its inability to communicate to others and is more aptly called "artwork."

Kris (1952), mentions some common characteristics of schizophrenic artwork: disconnected and rigid structures, unintelligible configurations, human figures which are particularly stiff, unnatural and artificial, with empty facial expression.

Connections have been made in the literature between the artwork of schizophrenics and dreamwork. Dreamwork was defined by Soloman and Patch (1971) as the agency responsible for the distortion of the latent (underlying unconscious wishes) into the peculiar form and appearance of the manifest content (observable, recallable content) which was the dream as recalled by the dreamer. Both dreamwork and artwork were motivated by unconscious forces, both contained manifest and latent aspects, and both were subject to primary and secondary processes. Primary processes applied to a type of wishful thinking dominated by emotions and characterized by such features as condensation or compression of ideas, displacement or substitutions, and symbolism or pictures representing forbidden ideas. Secondary process thought was characterized by logic, delay, and objectivity.

In artwork, Kris (1952) connected the dream processes of displacement, condensation, and symbolization with the creation of forms.

In visual terms, Arieti (1969) noticed that primary process is expressed as fusion or condensation into bizarre forms. The picture represents a "word salad," a conglomeration of things, or the cognitive structure of the primary process, the "primary aggregation."

According to Aksel, Koptagel, Elbirlik and Wharton (1969), condensation is viewed in schizophrenic artwork when objects and organisms can be themselves and something else at the same time. They both emit and receive forces, powers, and mystical qualities. Condensation appeared to Reitman (1950) as "composite figures." The notions of time and space are not distinguished in this type of "prelogic" thinking (primary process), whereas in normal thinking (or secondary process), the causal connection is strictly bound by categories of time and space.

In schizophrenics, Kris (1950) noted a distinct "urge to create" which Davidson and Wise (1957) called an expression of "psychic needs." The degree and amount of expression appeared to mirror the degree of disorganization of the total personality. Marinow (1969), in agreement with Kris (1950) found psychotic artwork to be a restitutive attempt to express graphically an inaccessible

world, and to create a preverbal communication with the environment.

But Kris's (1950) main contribution is the concept of participation of the ego in art productions. He maintains that although the psychotic artist and the artistically active normal may employ the same mechanism, each is working within an entirely different context. The psychotic is following the laws of "primary process," or the language of the id, while the normal artist's ego is maintaining control over the evidences of unconscious "primary process" elaborations to prevent distortion.

Francis Reitman (1950) supports Kris's contention, stating that "the normal artist remains aware of reality as it is and knows that he has deliberately restructured it in his art product, "while the works of schizophrenics reveal no such deliberate restructuring but a "disintegration of perceptual relations and a dissolution of concepts."

"Through the complex patterns on relations of form and color," Arieti stated that "harmonious fusion" occurs in normal art. (1969)

Expounding on this dichotomy between schizophrenic and normal artwork, Arieti (1969) and Plokker (1965) pointed out the group's differences in the process of creation. They state that the healthy artist--to whatever movement he belongs--shows intellectual expansiveness;

while the schizophrenic's concretization impoverishes the original idea and makes it absurd and disconnected from reality.

Anastasi and Foley (1944) concluded that patient artwork was more delusional and disintegrated with a larger range of unrelated objects. There was more inconsistency in the amount and distribution of color, and more unrelated writing on the artwork. Naumberg (1950) also perceived the tendency to combine art and writing as had Simon and Lombrosco. (1876) Disproportion of size, lack of perspective, paranoid "maps" or "plans," crudeness, schematic style and distortion of objects were also noted.

There is much agreement relating to both the autistic qualities of schizophrenic artwork and the relationship of that artwork's content as an expression of internal experience versus artistic restructuring of external reality.

R. W. Pickford (1967 stated that the more aesthetically pleasing a piece of artwork was, the less likelihood that mental disorder existed.

Reitman (1950) states that in the graphic expression of mental patients the symbolism is often known only to the artist; thus it is autistic in its inability to communicate to others. Similarly, Edith Kramer (1971, Volmat (1956), Prinzhorn (1922, and Marinow (1969) found the character of art in its usual sense of communication

to be lost in psychotic artwork. Psychotics' artwork revealed an inner psychotic world more than a display of the real world. Andreoli and Saghia (1969) state that the artwork paralleled the patient's morbid thinking in the content of their drawings. Autism was seen as a result of the patient's alienation, and was manifested in the peculiarities of form and content in their artwork.

Arieti (1969) and Aksel, Koptagel, Elbirlik and Wharton (1969) agree that in schizophrenia there is a return to more primitive stages of development leading to disintegration and splitting of the ego. Schizophrenics' artwork correspond to this altered state....suddenly objects become enormous, cut-off, detached and without relation to one another, space appears limitless, and anxiety reigns. Reitman (1950) noted that proportion is often reversed, spatial relations are distorted and apathy is apparent. Reitman also noted, as did Marinow (1969), that body image deteriorates, and drawings show an absence of parts, and a loss of boundaries between the body and its surroundings.

The literature also reveals much agreement on the prevalent characteristics of schizophrenic artwork. Dagyolu, Koptagel, and Veliogu (1969) noted disturbances in the patient's feeling state or affect, as well as in his thinking. The thought disturbance was indicated by symbolism that showed predelusional ideas. The affectual

response was manifested by anxiety in the artwork. Arieti (1969) felt that this anxiety was transformed immediately into concrete representations due to the schizophrenic's inability to conceive and sustain abstract thought.

Marinow (1971) stated that synthesis was absent; figures became deformed and unrelated. The form and content of the artwork resembled that of the primitive, and were not part of the culture as it existed.

Born (1946) listed and defined seven characteristics in schizophrenic artwork as:

1. Intellectual realism or minuteness of detail.
2. Distortion or arbitrary treatment of proper and different perspective relationships.
3. Stiffness or rigid and tense outline which preserves isolated identity.
4. Space and repetition or multiplication of a few motifs leading to exaggerated stylization.
5. Obscure symbolism or autistic, non-communicative.
6. Imagined work--non-naturalistic in character.
7. Combined media--varied material and writing combined with artwork.

Frequent occurrence of white space in schizophrenic artwork was noted by Volmat (1960) as reflecting emptiness. Disintegration appears in the placing of space, strongly contrasting colors, and from isolation of objects with regard to one another.

Simon (1969) feels artistic style reveals the ability of the patient to integrate attitudes and experience. The lack of integration was noted by Day and Kwiatowska (1962) and Ohlmeirer and Cramer (1969) in schizophrenic artwork. The pictures were fragmentary, isolated and inappropriately titled. Figures were often shadowy, undifferentiated and totally isolated. While Zimmerman (1942) and Pickford (1967) elaborated on the characteristics of schizophrenic artwork as being bizarre in quality, autistic in scope, rigid, incomprehensible and fragmentary.

Several authors mention the use of art therapy with patient populations. Kris (1952) stated that style in patient artwork related to the capacity of the ego to perform; Reitman (1950) noted that changes in style are significant. This change in style can be equated with progress in therapy and is a significant tool for diagnostic and therapeutic techniques.

After studying cases of schizophrenic patients, Davidson and Wise (1957) found no impairment of these patients' ability to produce artwork and felt this capacity should be utilized as part of therapy.

Naumberg (1950) recognized the fundamental importance of the unconscious as expressed in a patient's dreams, daydreams, fantasies, and artwork, according to the principles of psychoanalysis. She stressed the symbolic aspects of patient artwork and the need for therapeutic interpretation of symbols.

The test chosen for this study was the Dergalis (1971) Art Therapy Evaluation Test, a four part comprehensive quantitative measure of art productions.

Dergalis used the test in viewing patient artwork obtained in a short-term treatment unit in which the average patient's stay was three weeks. She administered the test three times during hospitalization; the first test within forty-eight hours of admission, the second test one week later, and the last test shortly before discharge. Dergalis used three pictures each test: one free drawing, one scribble that the patient was asked to elaborate upon in terms of shape and images, and one copy of a small sculpture put in front of the patient. These pictures were evaluated for the following general criteria:

1. Aspects of Ego Disturbance
2. Aspects of Conflict
3. Orientation to Reality
4. Organic Disturbances--relating to brain dysfunction

These criteria were organized into demonstrable visual and graphic representations of psychiatric terminology related to pathology (See sample Evaluation Test, Fig. 1).

Section 1, Aspects of Ego Disturbance, lists items symptomatic of schizophrenia, paranoia, manic-depressive psychosis, depression, and aggression. Section 2, Aspects of Conflict and Anxiety, includes neurotic defenses,

especially those present in obsessive-compulsive disorders. Section 3 contains factors for rating the subject's reality testing ability. Section 4 consists of factors primarily seen in organic disturbances.

Dergalis also included an additional section. Section 5, which rated evidence of phobias, displacement and other items which required the subject's verbal associations for positive identification. This author did not provide any associations to drawings done for this study, and therefore deleted Section 5 of the test rating as well as a space in the original evaluation test for clinical impressions of the evaluation.

The rating system in the test was geared to a 0-3 scale: (0) indicated the item was not present, (1) slightly present, (2) moderately present, and (3) strongly present. These quantitative indicators were employed in order to be able to differentiate between subjects who manifest to varying degrees the same factors in their drawings and so might be either psychotically or neurotically disturbed.

Appendix A is a complete set of the definitions of terminology used in the art therapy evaluation test. These terms were taken directly from the Dergalis thesis, and are reproduced to simplify understanding of the test terminology; to clarify, and insure commonality in responses of raters.

CHAPTER III

PROCEDURES

Two groups of inpatients at the Mental Health Institute in Mount Pleasant, Iowa participated in this study. All subjects were requested to participate in two drawing tasks. The first task was to "draw a picture of a place that you would like to go." The second task (hereafter referred to as a name drawing) was to "write your name, fold the paper to create the mirror image of the name, and make the drawing into a picture by adding whatever colors, lines or shapes you think you need." The author presented each task to the groups of subjects and remained with the groups while the subjects completed the tasks.

The first group of subjects (Group I) consisted of ten patients who were diagnosed as being alcohol dependent. The group was composed of nine males and one female who ranged in age from twenty-two through fifty years of age. Three male subjects were negro and the other seven were caucasian.

The second group of subjects (Group II) consisted of ten patients who were diagnosed as being schizophrenic. In this group were eight males and two females ranging in

ages from twenty-three through forty. One subject was negro, one was Puerto Rican, and the remaining eight subjects were caucasian.

All diagnoses of the subjects were made by the psychiatric staff of the Mental Health Institute of Mount Pleasant, Iowa and not by the author of this study.

No widely accepted art therapy scale existed which rated or served to determine pathology seen within artwork. For the purposes of this study an artwork pathology rating system developed by art therapist Miriam Deregalis (1971) was adapted with minor modifications and employed in assessing pathology in artwork gathered within this study.

Five members of the Illinois Art Therapy Association who are employed as art therapists served as blind raters for this study. All raters were caucasian and ranged in ages from twenty-two through twenty-five. Four raters were female; one was male. All raters were unfamiliar with the subjects of this study and their diagnoses, and all were unaware of the purpose of this study other than the study's having been related to an art therapy thesis.

Each rater was given a copy of the rating scale and a listing of definitions of the terms used within the rating scale (Appendix A) one week prior to review of the artwork. On two subsequent evenings spaced at one week intervals each rater was asked to view 2¼" by 2¼" slides

of each subject's artwork, completing one rating scale for each slide which was presented.

Although most of the raters had studied and were familiar with the terminology on the rating sheet, there were many questions during the first few slides. Each rater had a copy of the "definitions of terminology" with them during the rating, and these were referred to often for clarification. As the evaluation sheet was detailed and lengthy, each slide was kept on the screen for ten minutes.

The rating scale material was collected and scores were tallied for both groups as to the individual variable, rater, and set number. Charts and graphs were made to display the totals for both groups according to each variable.

T-tests were subsequently done to determine the statistical significance of the data gathered.

The addendum will further explain the results of the T-tests.

FIGURE 1

ART THERAPY EVALUATION TEST

	Pict. #1	Pict. #2	Totals
I. Aspects of Ego Disturbance			
1. Fragmentation or disorganization	___	___	___
2. Splitting	___	___	___
3. Confusion	___	___	___
4. Unbalanced use of space	___	___	___
5. Orality	___	___	___
6. Flatness of affect	___	___	___
7. Primitiveness	___	___	___
8. Symbiosis	___	___	___
9. Distortion of body image (parts exaggerated), missing or misplaced)	___	___	___
10. Transparency	___	___	___
11. Persecutory figures or objects (ideas of reference	___	___	___
12. Diffuseness	___	___	___
13. Concreteness (labelling)	___	___	___
14. Images showing estrangement from self or surroundings (depersonalization)	___	___	___
15. Flight of ideas	___	___	___
16. Other expressions of mania	___	___	___
17. Expressions of depression in color, shape or image	___	___	___
18. Suicidal imagery	___	___	___
19. Expressions of aggression in color, shape or image	___	___	___
20. Isolation	___	___	___
21. Symbolization	___	___	___
22. Patient denies connection with the picture (dissociation)	___	___	___
23. Other expressions of denial	___	___	___

FIGURE 1 (cont'd)

	Pict. #1	Pict. #2	Totals
II. Aspects of Conflict and Anxiety			
24. Messages	___	___	___
25. Ambivalence	___	___	___
26. Turbulance	___	___	___
27. Repetition	___	___	___
28. Geometric picture puzzle-like designs	___	___	___
29. Excessive detail	___	___	___
30. Tightness	___	___	___
31. Intensity of line	___	___	___
32. Intensity of color	___	___	___
33. Intensity of both line and color	___	___	___
34. Erasures	___	___	___
III. Reality Orientation			
35. Incompleteness	___	___	___
36. Discrepancies in form	___	___	___
37. Discrepancies in color	___	___	___
38. Discrepancies in detail	___	___	___
39. Mistakes in proportion	___	___	___
40. Mistakes in color	___	___	___
41. Mistakes in lines	___	___	___
IV. Organicity			
42. Perseveration			
43. Inability to make or complete geometric shapes			
44. Unsteady or shaky lines			
45. Reversal			
46. Spaces between related objects which should be touching (i.e. cup and saucer)	___	___	___

CHAPTER IV

USE OF THE ART THERAPY EVALUATION TEST

The art therapy evaluation test used in this study was devised by Miriam Dergalis, a 1971 graduate of Hahnemann Medical College in the Art Therapy Masters program. Ms. Dergalis's purpose in using this test was quite different from the author's.

The author's decision to use the art therapy evaluation test was prompted by the difficulty in formulating such a measure. The translation of concepts of psychiatric pathology into a concise, concentrated scale of equivalent graphic representations in a comprehensive, standardized rating system has greatly facilitated this research.

Part 3, Reality Orientation, was originally intended by the creator of the rating system to test a patient's perception of a piece of sculpture concretely put before him or her in reality. It is possible, and useful, to make these judgments about any drawing, according to the definitions of terminology numbered 35 to 41. The raters reported no particular difficulty with this part of the test, and were able to make the decision whether or not a particular factor was present in a drawing, but the degree to which it was present was a more subjective and less consistent judgment. This factor

was noted also by Dergalis's paper as meriting more analysis.

The task of completing a full qualitative and quantitative evaluation on each slide, with a sample of forty slides (two drawings per subject) necessitated that the raters spent long hours viewing slides.

CHAPTER V

RESULTS

The graphs and charts in the following pages contain the quantitative results of this comparative study.

In the category of ego disturbance Figure 2 presented the mean scores of five ratings of twenty drawings, ten drawings of which were done by an alcoholic population; and ten drawings of which were done by a schizophrenic population.

It is important to remember that higher scores indicate more pathology in that area; for example, a score of 20 in reality orientation indicates a higher level of pathology than a score of 5 in that same area.

The results of the alcohol dependent group in ego disturbance (Figure 2) indicate a slightly higher level of pathology. The highest score was picture 1 with a score of 35; while the highest score of the schizophrenic group was picture 12 with a score of 34. The lowest score in the alcohol dependent group was picture 3 rated at 12; while the lowest score of the schizophrenic group was slide 19 rated at 18.

The alcohol dependent scores were more erratic, ranging from 12-35; while the schizophrenic scores were more stable ranging from 18-34. Both a wider scattering within

scores and means, as well as higher pathology were indicated in the alcohol dependent artwork in Figure 2.

In the chart of totals (Figure 9), it was evident that the overall rating on the amount of ego disturbance for the alcohol dependent (1363) was higher than the ratings of the schizophrenic group (1299).

Aside from the higher scores on the slides in the alcohol dependent group, it should be noted that the total scores of the schizophrenic group and alcohol dependent group in Variables I, II, III were relatively close (See charts, Chapter V).

In the category of Ego Disturbance, the Schizophrenic group rated a total score of 1299, compared with 1363 for the alcohol dependent group. Drawings by the alcohol dependent group were scored 762 in conflict and anxiety, compared with 669 given to the drawings of the schizophrenic group.

In reality orientation, schizophrenic drawings tallied 69, while alcohol dependents received a score of 70. Organicity scores were 1 and 59 respectively, for the schizophrenic and the alcohol dependent.

The addict group apparently had a higher level of conflict and anxiety than had the schizophrenic group. The results would seem to be in keeping with many theories of alcohol dependency as discussed within Literature Review, Chapter II.

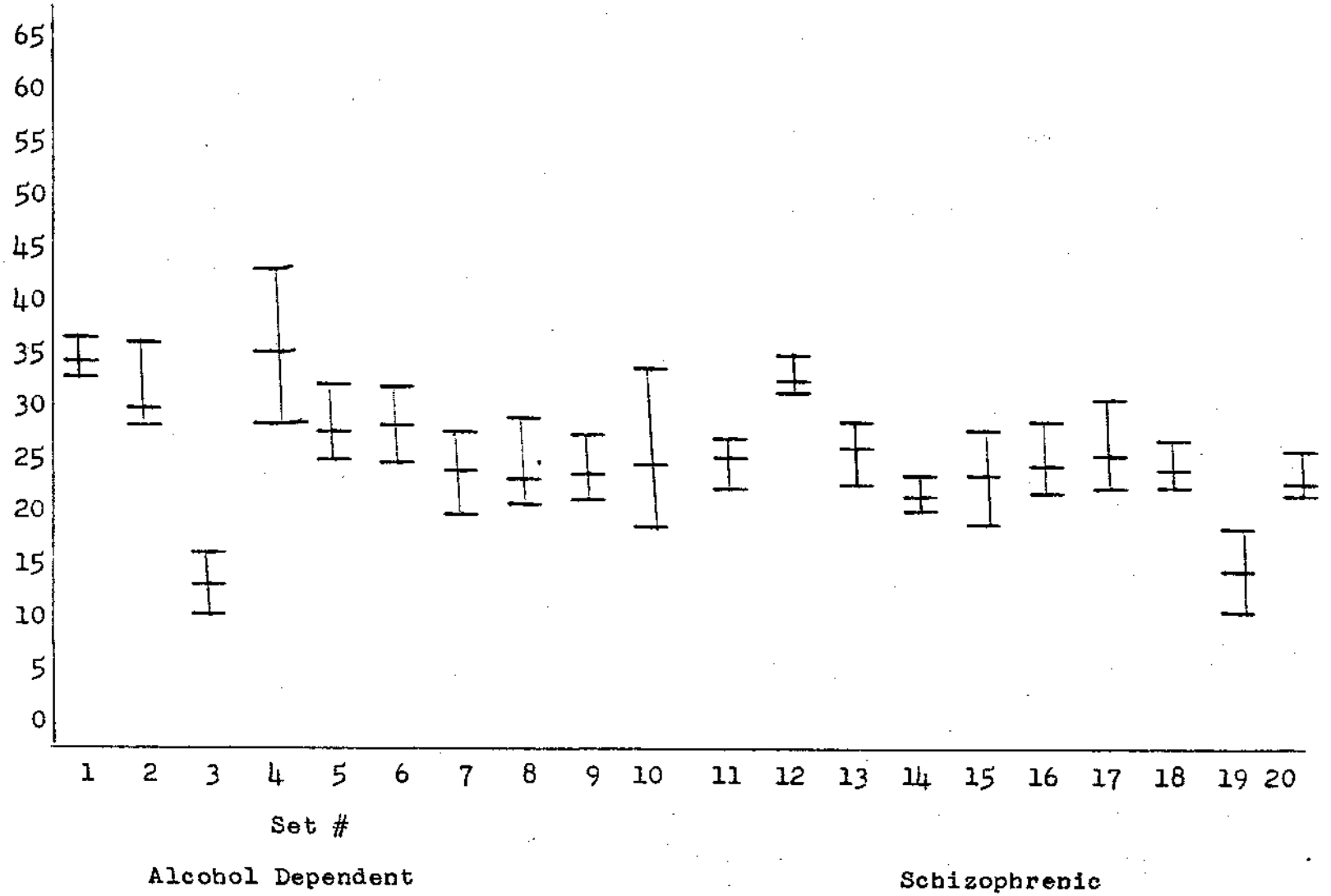
In the T-test (see addendum), it was evident that no significant statistical difference was established between

pathological expressions in the artwork of alcohol dependents and schizophrenics.

FIGURE 2

Condition I - Aspects of Ego Disturbance

Graph of Means and Highest and Lowest Ratings



The total results of the alcohol dependent group in conflict and anxiety (Figure 3) indicate a slightly higher level of pathology. The highest total score was picture 2 with a score of 24; while the highest total score of the schizophrenic group was 16 with a score of 18. The lowest total scores in the alcohol dependent group were slides 5, 6, 10 rated at 11; while the schizophgrenic group's lowest slides were 19, 20 rated at 6.

The alcohol dependent total scores were more erratic, ranging from 11-24; while the schizophrenic mean scores were more stable ranging from 6-15.

The highest pathology rating for the alcohol dependent slides was slide 1 at 30, while the lowest was slide 5 at 5. The highest and lowest ratings for the schizophrenic group were respectively slide 16 at 19, and slide 19 at 3.

In the chart of totals (Figure 9) it was evident that the overall rating on the amount of conflict and anxiety for the alcohol dependent group (762) was higher than the schizophrenic group (669).

The total results of the alcohol dependent group in reality orientation (Figure 4) indicate a slightly higher level of pathology. The highest total score in the alcohol dependent group was rated 2 for slides 2, 7. The highest total score for the schizophrenic group was slide 20 at 3. The lowest total score of 0 appeared in slides 1, 4, 6, 10

FIGURE 3

Condition II - Aspects of Conflict and Anxiety

Graph of Means and Highest and Lowest Ratings

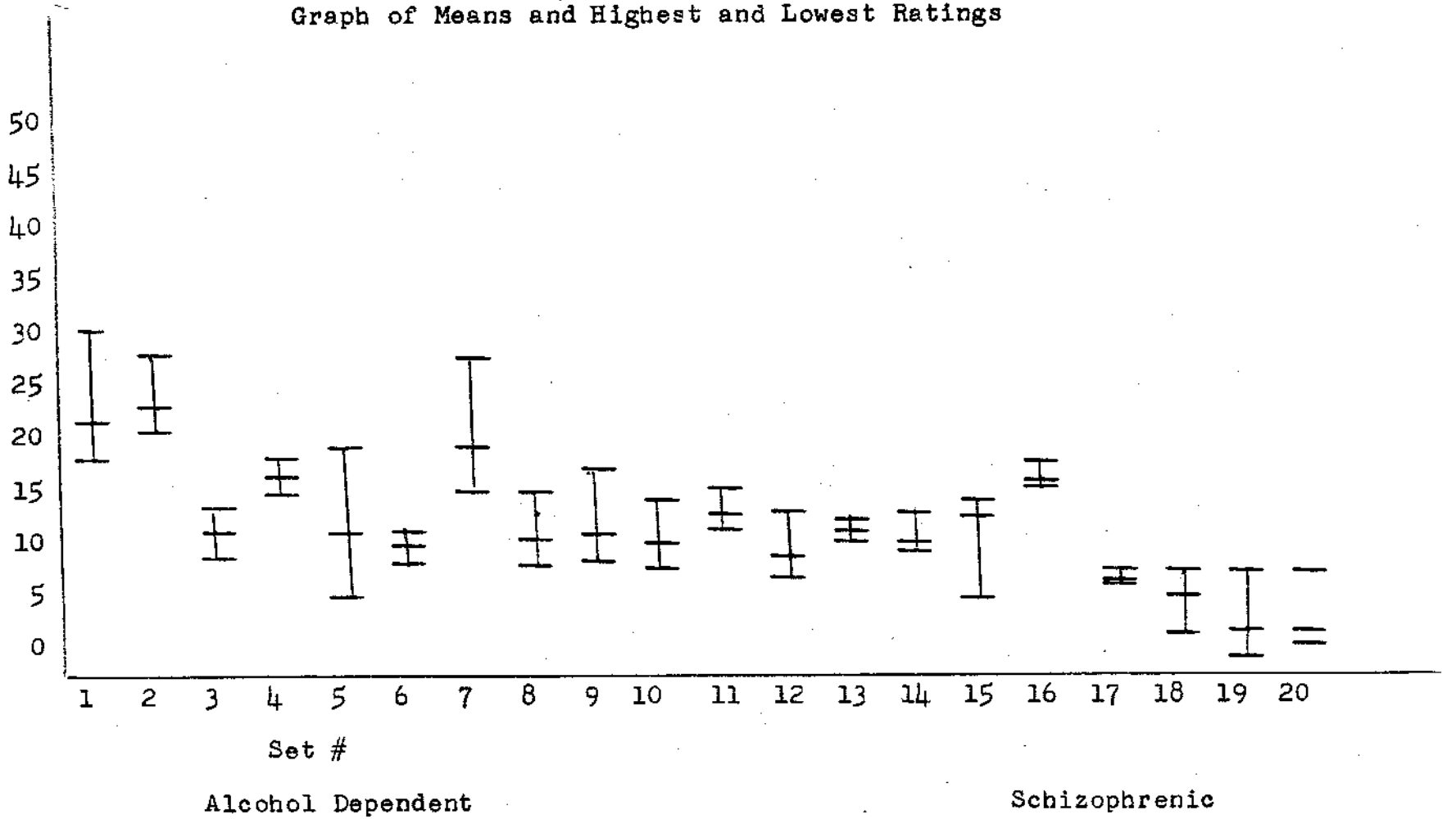


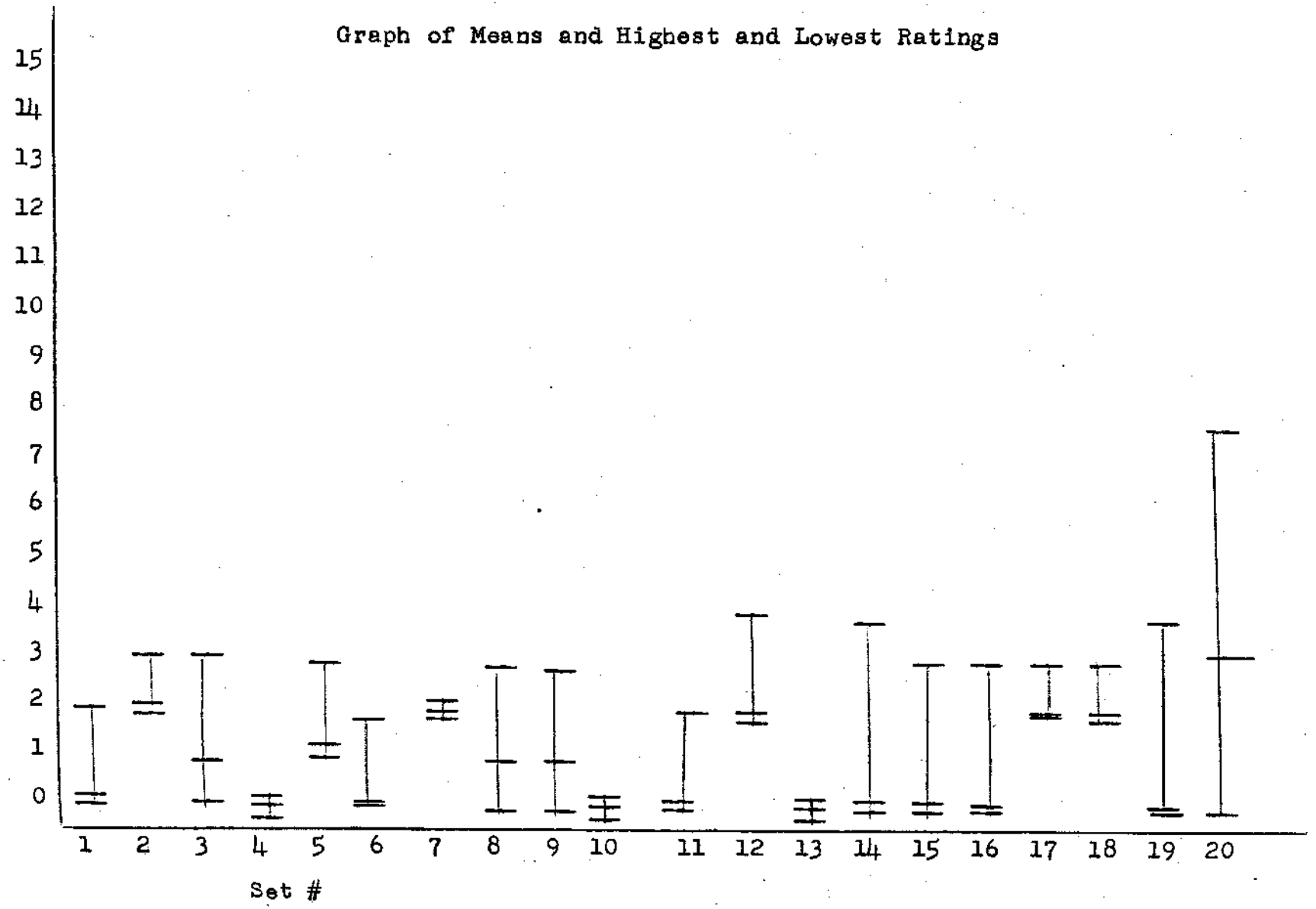
FIGURE 9

	Schizophrenics	Alcohol Dependent
Condition I Ego Disturbance	1299	1363
Condition II Conflict and Anxiety	669	762
Condition III Reality Orientation	69	70
Condition IV Organicity	1	59
Isolation	177	176

FIGURE 4

Condition III - Reality Orientation

Graph of Means and Highest and Lowest Ratings



of the alcohol dependent slides and 11, 13, 15, 16, 19 of the schizophrenic slides.

The highest pathology rating of 3 for the alcohol dependent slides were slides 2, 3, 4, 8, 9 while the lowest was 0 for slide 10. The highest and lowest ratings for the schizophrenic group were respectively slide 20 at 7 and slide 13 at 0.

In the chart of totals (Figure 9) it was evident that the total rating on the lack of reality orientation was slightly higher for the alcohol dependent.

The total results of the alcohol dependent group in organicity (Figure 5) indicate a higher level of pathology. The highest total score in the alcohol dependent group was slide 1 with a score of 5. All total scores for the schizophrenic group slides were 0.

The total scores of the alcohol dependent group were more erratic, ranging from 0-5. However, this category showing organicity ratings showed the most consistently low scores.

In the chart of totals (Figure 9) it was evident that the organicity score was higher for the alcohol dependent group.

Figure 6 indicated that the scores for the defense of isolation showed slightly higher pathology for the schizophrenic group. Again, the alcohol dependent group showed a wider range of variation including both the

FIGURE 5

Condition IV - Organicity

Graph of Means and Highest and Lowest Ratings

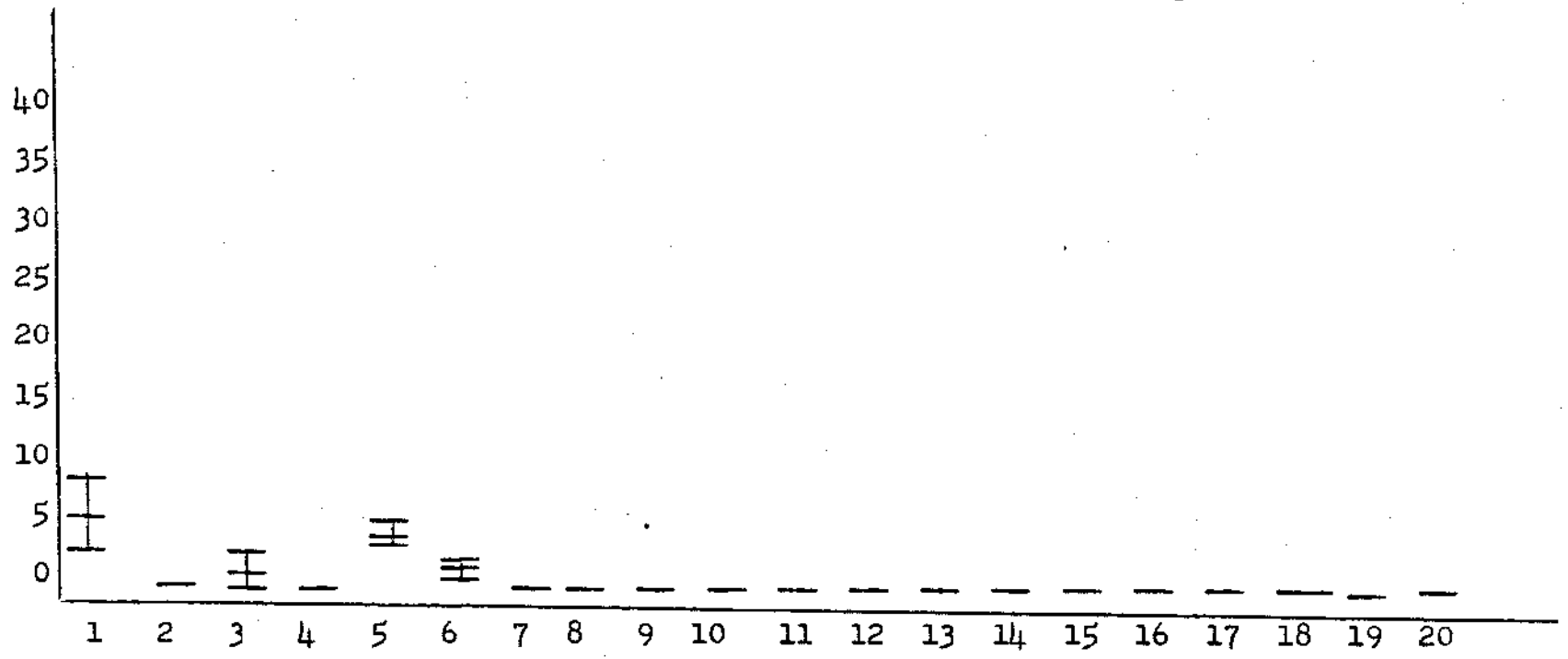
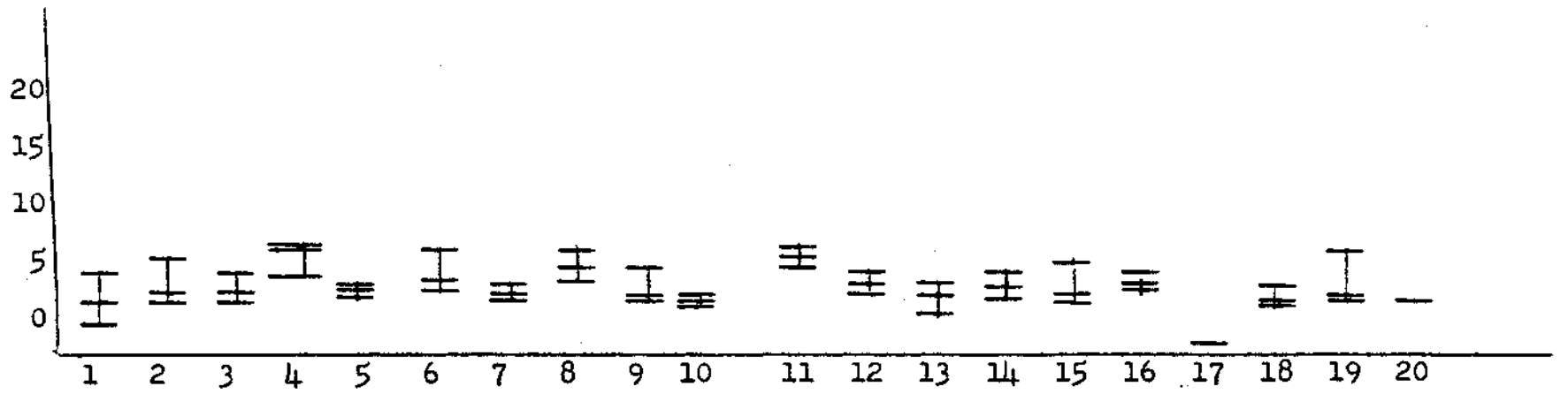


FIGURE 6

Isolation - Means Plus Highest and Lowest Ratings



highest and lowest scores. The schizophrenic group appeared more stable with set numbers 17 and 20 scored the same by each rater. In the chart of totals (Figure 9), it was evident that the overall rating on the amount of isolation was only slightly higher for the schizophrenic group.

Figures 7 and 8 detail the breakdown of individual ratings for each subject group by rater and by variable, indicating instances of moderate scattering in the scores of different raters on the same slide. For example, slide number 4 (see Figure 7) was scored by rater A as 29, and by rater E as 44 in the area of ego disturbance. Figure 8 shows an even slighter scattering. For example, slide number 16 (see Figure 8) was scored by rater C as 24, and by rater E as 29.

Figure 9 demonstrates the total scores by all raters in each area for the alcohol dependent and schizophrenic group scored 1299 to the alcohol dependent 1363. In conflict and anxiety the schizophrenic group scored 669 to the alcohol dependent 762. In reality orientation the alcohol dependents scored 70 to the schizophrenic score of 69. The organicity ratings for the schizophrenic group rated 1 while the alcohol dependents rated 59. The defense of isolation scores were 177 for the schizophrenic and 176 for the alcohol dependents.

FIGURE 7

ALCOHOL DEPENDENT DRAWINGS

Rater A

CONDITION	Set Number 1	2	3	4	5
I	36	28	13	29	29
II	18	21	12	16	14
III	2	2	2	0	2
IV	5	0	0	0	5
	6	7	8	9	10
I	33	20	33	22	19
II	12	16	16	12	12
III	2	2	2	2	0
IV	2	0	0	0	0

Rater B

	1	2	3	4	5
I	34	36	10	32	25
II	30	28	14	17	19
III	2	3	2	0	1
IV	2	0	0	0	4
	6	7	8	9	10
I	31	25	25	24	26
II	12	16	13	16	11
III	2	2	2	2	2
IV	1	0	0	0	0

Rater C

	1	2	3	4	5
I	35	31	16	34	32
II	22	26	12	18	12
III	0	2	0	0	2
IV	8	0	1	0	5
	6	7	8	9	10
I	29	24	21	25	34
II	10	16	9	19	10
III	0	2	3	3	2
IV	0	0	0	0	0

FIGURE 7 (cont'd)

	Rater D			Set Number	
	1	2	3	4	5
I	35	24	12	35	28
II	20	26	14	17	5
III	0	2	3	0	3
IV	7	0	2	0	5
	6	7	8	9	10
I	27	27	25	28	26
II	12	25	12	10	16
III	0	2	2	0	4
IV	0	0	0	0	0

	Rater E				
	1	2	3	4	5
I	34	32	13	44	29
II	20	23	9	15	5
III	0	3	0	0	1
IV	6	0	1	0	4
	6	7	8	9	10
I	25	29	22	23	24
II	9	29	12	12	9
III	0	2	0	0	0
IV	1	0	0	0	0

FIGURE 8

SCHIZOPHRENIC DRAWINGS

CONDITION

Rater A

	Set Number				
	11	12	13	14	15
I	29	36	27	23	28
II	14	15	15	16	17
III	0	2	0	0	0
IV	0	0	0	0	0
	16	17	18	19	20
I	27	23	27	15	25
II	18	9	10	4	10
III	3	2	2	2	4
IV	0	0	0	0	0

Rater B

	11	12	13	14	15
I	28	35	23	24	28
II	15	12	15	14	17
III	0	4	0	2	0
IV	0	0	0	0	0
	16	17	18	19	20
I	27	30	28	19	23
II	18	10	10	4	9
III	0	2	3	0	7
IV	0	0	0	0	0

Rater C

	11	12	13	14	15
I	26	39	28	24	20
II	16	10	14	13	6
III	0	3	0	2	0
IV	0	0	0	0	0
	16	17	18	19	20
I	24	24	23	19	25
II	19	9	5	3	5
III	0	2	3	0	2
IV	0	0	1	0	0

FIGURE 8 (cont'd)

Rater D

	Set Number				
	11	12	13	14	15
I	25	36	26	22	28
II	17	10	15	14	18
III	2	3	0	0	3
IV	0	0	0	0	0
	16	17	18	19	20
I	25	32	28	20	27
II	19	9	5	9	5
III	0	3	2	2	2
IV	0	0	0	0	0

Rater E

	11	12	13	14	15
I	24	36	26	21	25
II	16	9	14	13	17
III	0	2	0	0	0
IV	0	0	0	0	0
	16	17	18	19	20
I	29	28	23	18	23
II	19	9	10	10	5
III	0	3	2	0	0
IV	0	0	0	0	0

The bar graphs (Figures 10-14) further demonstrate the total scores between the alcohol and schizophrenic groups within each condition

It should be noted that scores between the areas covered cannot be compared, since the scales were completely different for each. (See Figure 1). For example, Condition 1, with a maximum possible vertical score of 138 (23 possible horizontal scores of 6) cannot be compared with Condition III, which has a maximum vertical score of 42 (7 possible horizontal scores of 6). The only comparisons that can be meaningful are those within a condition, between groups, between individual slides and between raters.

Overall, the alcohol dependent group demonstrated the most erratic characteristics, both between raters, and within the group. This phenomenon is discussed in Chapter VI.

An obvious and noticeable result was the higher pathology scores of the alcohol dependent group in all categories except condition IV, Organicity, which is noticeably higher and Isolation which is slightly lower. The most consistently low scores for both groups were indicated in the Organicity and Reality Orientation graphs.

FIGURE 10

BAR GRAPHS OF TOTALS:

CONDITION I - ASPECTS OF EGO DISTURBANCE

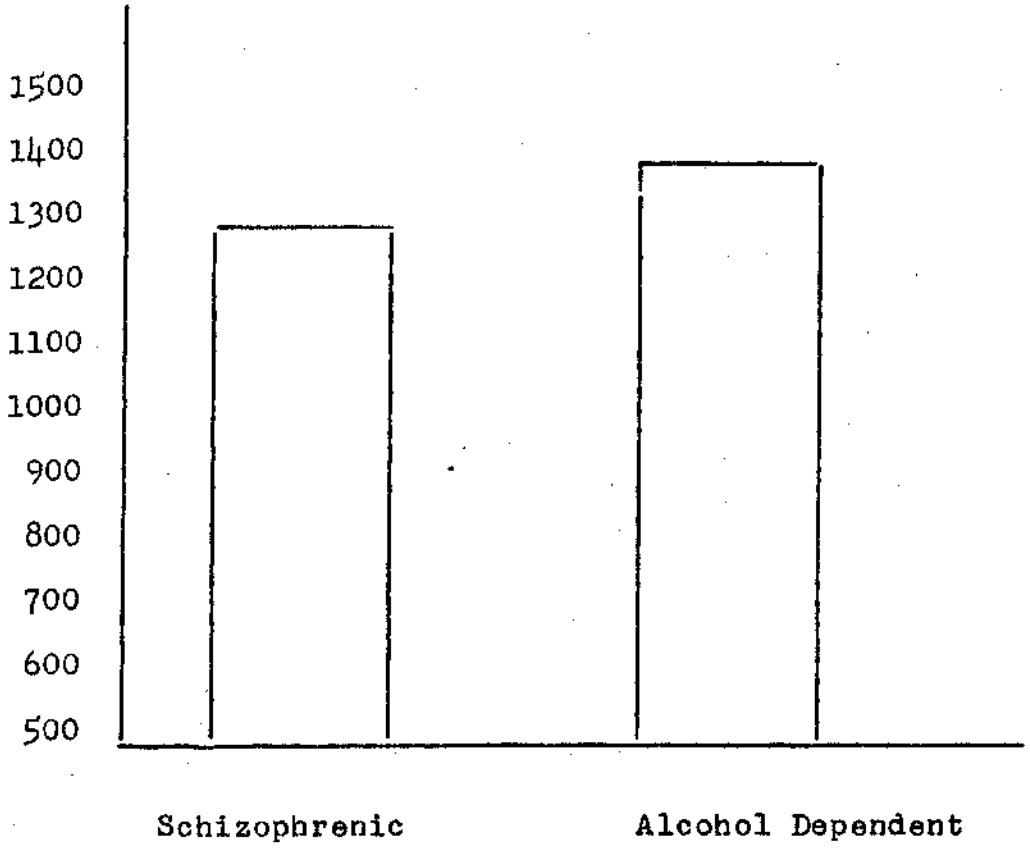


FIGURE 11

BAR GRAPHS OF TOTALS:

CONDITION II - ASPECTS OF CONFLICT AND ANXIETY

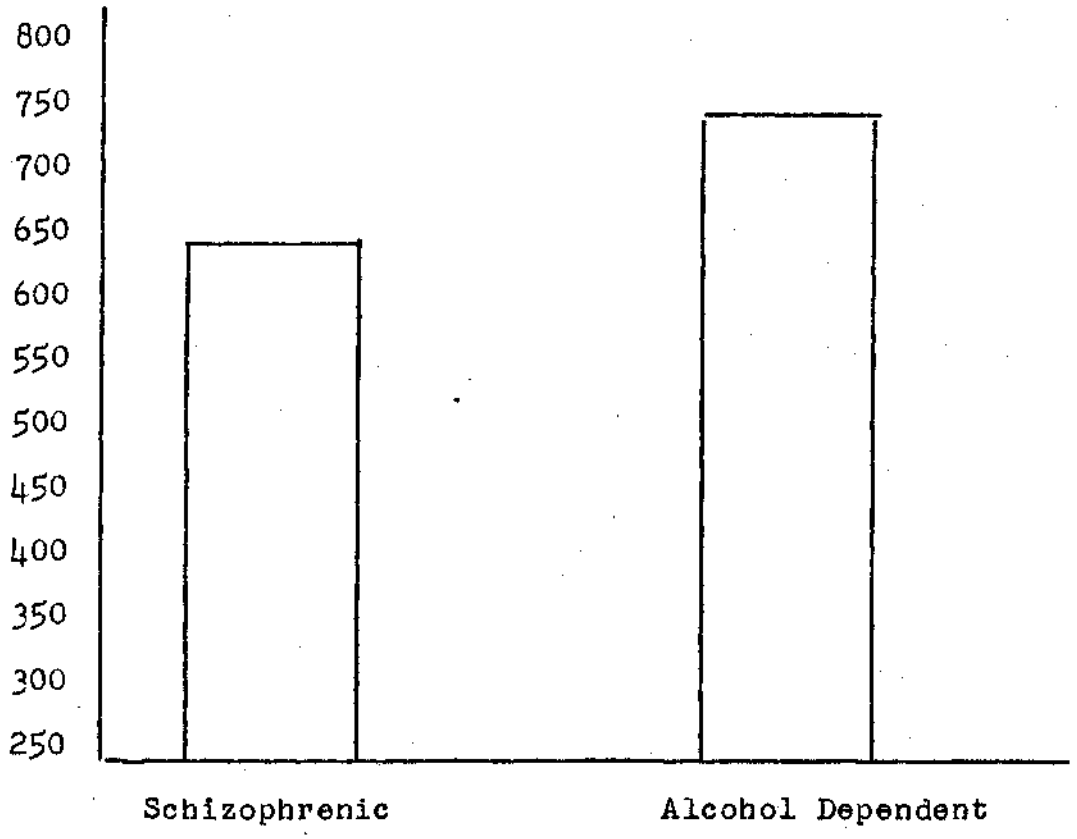


FIGURE 12

BAR GRAPHS OF TOTALS:

CONDITION III - REALITY ORIENTATION

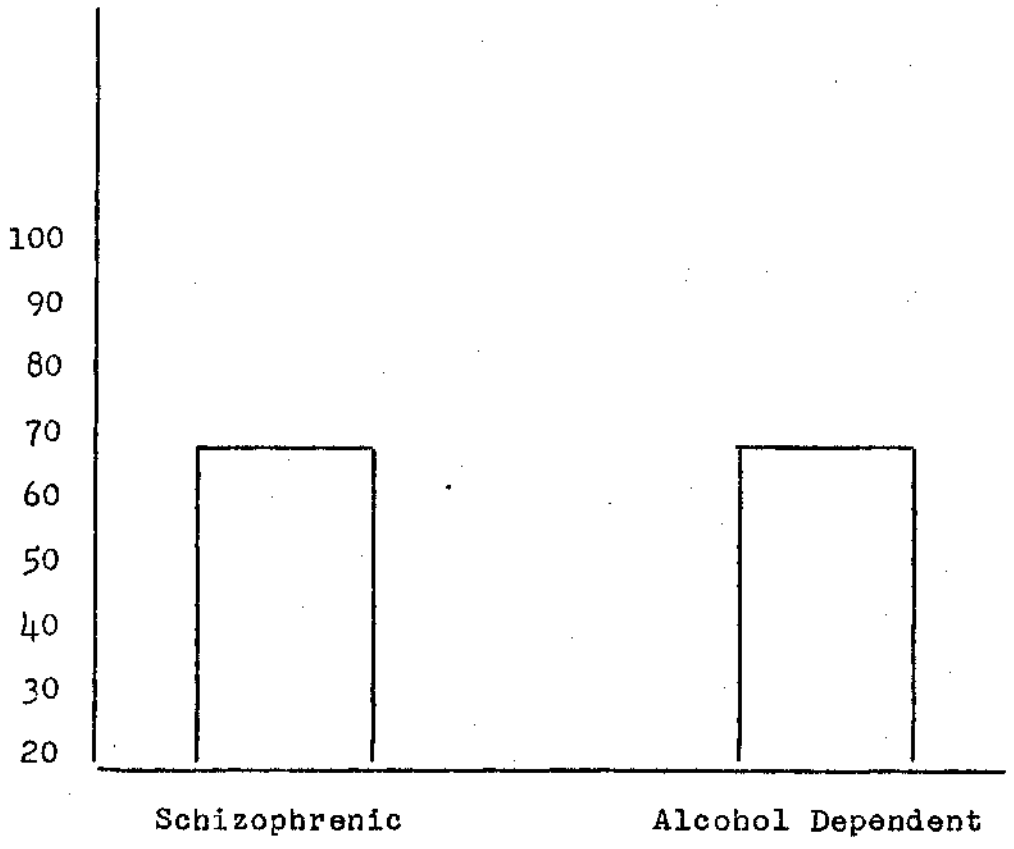


FIGURE 13

BAR GRAPH OF TOTALS

CONDITION IV - ORGANICITY

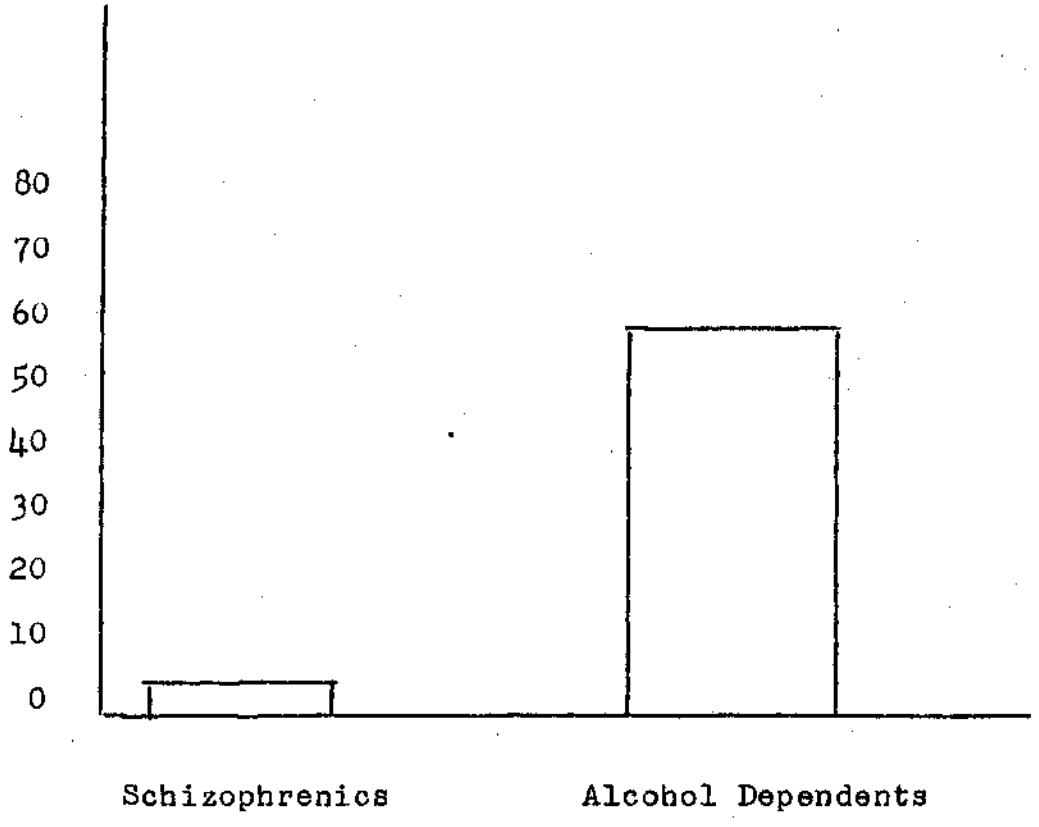
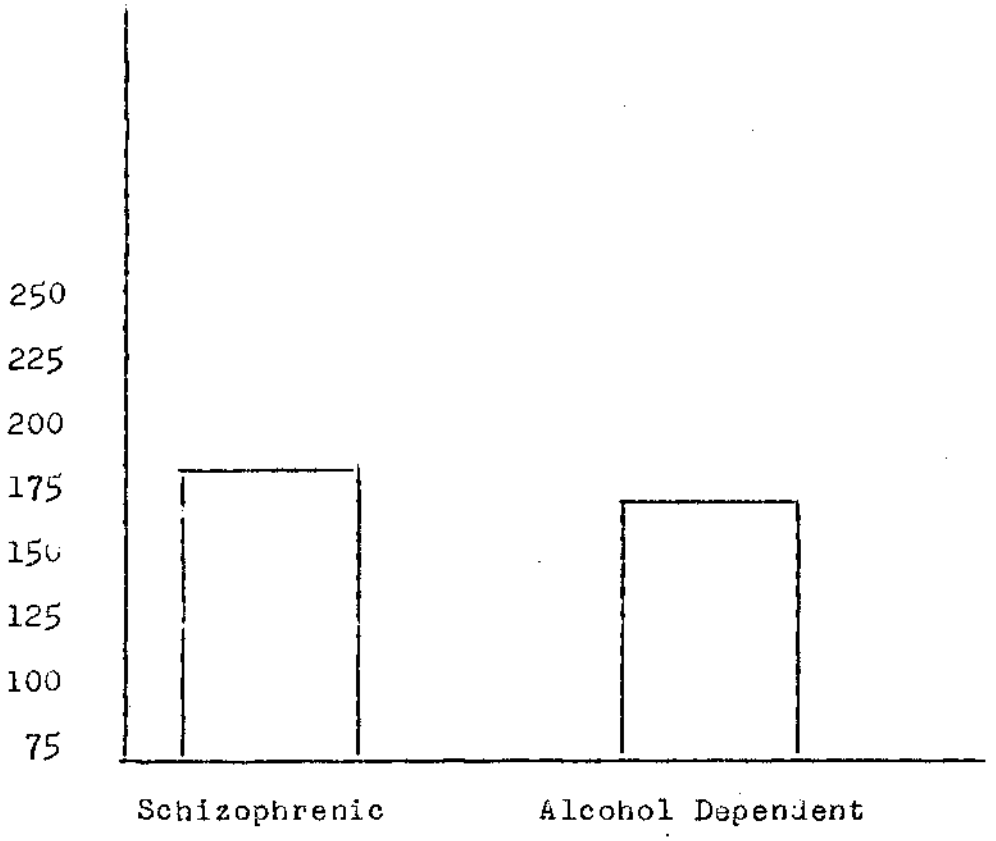


FIGURE 14

BAR GRAPH OF TOTALS

ISOLATION



CHAPTER VI

ANALYSIS AND IMPLICATIONS

The results of this experiment would seem to support the original hypothesis that there is no difference in the manifestation of the defense of isolation in the artwork of alcoholics and that of schizophrenic psychiatric patients. However, some of the results seem somewhat startling from the perspective of the author's work in the field of alcoholism. The alcohol dependent group scored higher pathology with greater scattering in most of the categories.

A number of possible explanations exist. The time span at which the drawings were gathered during the course of treatment may not have been adequately considered. The alcohol dependent group completed the drawing tasks just after detoxification, a period of little defensive capacity. The schizophrenic group completed the task during restitution and discharge planning. These factors may influence the slightly higher scores by the alcohol dependent drawings in most categories.

The wider scattering of scores in the alcohol dependent drawings may reflect the wider range of pathology and defensive manuevers (see Chapter II) used in this psychopathology.

Aside from any considerations of the group's testing procedures, there are problems related to the Art Therapy Evaluation Test itself which may be a cause of the higher scores that raters assigned to the art productions of the alcohol dependent group. The test was designed for use with a narrowly defined population of hospitalized mental patients by Dergalis (1971). The test was originally designed as a quantitative pathology rating scale, and provides a vast amount of information on the amount and degree to which an individual's art productions manifest evidence of a number of specific graphic characteristics associated with psychopathology.

But significantly, the test makes no provision for the qualitative detection of ego strength, of coping mechanisms, or of ability to function in everyday life. Thus, the test may be too heavily "weighted" in favor of indications of psychopathology to yield accurate psychological evaluations in any application.

The difficulty lies in the fact that all drawings manifest ego problems, conflict, and anxiety. These are universal characteristics especially evident in art productions, even those with evidence of normal ego defenses. For example, the drawings of neurotics are recognized to manifest many of the same overt conflicts and problems that art productions of psychotics and others with

more severe ego disturbances express. But psychotically disturbed individuals expend most of their energy defending against, and denying conflict. Thus, they have less energy available for coping. The alcohol dependent person defends against and denies conflict; but also manifests psychopathology differently. The Dergalis test is unable to qualitatively depict the relationship of the ego deficits to functioning within reality.

Another difficulty with the Dergalis instrument may be the 0 - 3 rating scale, which was intended to pick up differences in degree of disturbance on each of the graphic items. This may not allow for fine discriminations on the part of the raters, and a scale ranging from 0 - 10 might have provided greater disparities in scoring, and consequently, more easily understandable results.

For an evaluation test to be successful with widely varying populations, it must be able to detect evidence of ego strengths and coping ability as well as detecting evidence of psychopathology. The Dergalis art therapy evaluation test was used in this study, in spite of its difficulties, because it is the only such instrument designed for use within Art Therapy that the author was able to discover.

A great deal of consideration, experimentation, time,

and energy could well be devoted to the development of a more standardized and widely applicable instrument. For such an instrument to be used effectively, in most clinical applications it would require that the rater have access to information about the everyday life of the patient being evaluated. Such information is invaluable because it puts the material manifested in the drawings into a context and a perspective.

In this study, background information was deliberately withheld from the raters because of the structure of the experiment. The experimental design required that the raters not have information which would help them to identify the diagnosis of either of the two groups being evaluated. It was assumed that background and contextual information about the subjects would nullify the double-blind design. Apparently, one of the most important implications of this experiment is that background and contextual information about the subjects provides necessary input to the evaluator's judgment. Evaluations made without this information appear to be biased and inadequate. Karl Menninger (1938), P. F. Schilder (1941), and Ronald Cantanzaro (1968) stated the significance of background information to understanding the alcohol dependent. As Pickford (1967) wrote: "Pictures born of the unconscious can at most be grasped, or felt, individually...."

Another aspect of the unexpectedly higher scores for alcohol dependent persons is that raters were uniformly prepared to evaluate the drawings of patients, as they do every day in their work. The raters were told only that two populations were represented in the slides--As previously indicated, they were not told the group's diagnoses.

As a result of the lack of background information on the subjects, the judgments of the raters were made more difficult. Moreover, years of evaluating frankly pathological art productions is likely to have increased the raters' skill in detecting signs of psychological disturbances and may have decreased their ability to discern healthy aspects that may be present.

Aside from the higher scores on the slides in the alcohol dependent group, it should be noted that the total scores of the schizophrenic group and alcohol dependent group in condition I, II, III were relatively close (See charts, Chapter V).

In the category of Ego Disturbance, the Schizophrenic group rated a total score of 1299 compared with 1363 for the alcohol dependent group. Drawings by the alcohol dependent group were scored 762 in conflict and anxiety compared with 669 given to the drawings of the schizophrenic group.

In alcohol dependents the coping (or defense) mechanisms may not operate sufficiently well to make anxiety and conflict tolerable, so they may escape temporarily through the compulsive use of alcohol. In a sense, they may be denying the conflict through the use of a chemical defense or escape, as stated by Freud (1930), Rado (1953), Kalant (1971), Griffith (1974), and DeWitt (1952).

The defense itself might become a way of life because the alcohol dependence can make its own demands on the alcoholic. As Anna Freud (1946) stated, when the ego seeks to defend itself against instincts, it must ward off the affects also. This type of defensive preoccupation leaves little energy for facing problems or dealing with conflicts. Marianne Eckardt (1960), writes of the "detached person" who is unable to have energy for internal or external functioning. In effect, the alcohol dependent has avoided the intrapsychic conflict by adopting this lifestyle.

Alcohol dependents who are in treatment, as were the people represented in the group in this study, have more free time. These people were participants in a hospital treatment program which provided therapeutic activities and antabuse. But it may not have substituted for the lifestyle needed to fully escape from conflict. A great deal of time and

energy was freed up and made available for other pursuits. But this can be a very threatening situation, and may have been manifested in the high level of conflict and anxiety in the drawings.

Since the patients no longer had alcohol to pacify their anxiety, they argued and harassed one another constently. The fashion of the alcohol dependent's participation in activities reflected both the high level of agitation and conflict as well as their ritualistic ways of dealing with situations.

There always seemed to be an enormous amount of tension and deeply felt frustration in the surroundings of the unit which infrequently found a socially acceptable outlet. It was as if everyone were trapped and waiting for a situation to alleviate his or her fromidable tension arising from internal strivings, low self esteem, and feelings of isolation.

This pattern may well be attributable to the higher conflict and anxiety scores found in the alcohol dependent drawings.

High scores in condition IV, Organicity, may be related to alcohol use.

The low score in reality orientation attributed to

the schizophrenic group also deserves explanation. The scores seemed low when considering that psychoses most often breaks with and/or retreats from reality. However, it seems a prominent factor that most of the schizophrenic participants in this study had treatment for months, were restituting, and planning discharge. Therefore, most of their capacities for reality orientation would be functioning at their highest levels. However, the alcohol dependent participants were treated in a shorter term format and drew their pictures soon after the detoxification process ended. The alcohol dependent participants therefore were at a point in the process of their illness where pathology would be more evident in terms of reality orientation.

There was no significant difference between the total pathology scores and the isolation scores of the schizophrenic and the alcoholic group in the area of ego disturbance. The author, in the introduction, Chapter I, had anticipated this result; however due to a measure of pathology, rather than due to many weaknesses in the test design.

This result points to general evidence of underlying psychopathology and isolation problems in the artwork of alcohol dependents comparable to schizophrenic patients. If these results are accurate, treatment for alcohol dependent persons should be made more intensive, and should provide a structured therapeutic milieu after detoxification, as well

as support systems after discharge.

Existing alcohol treatment programs may require improvement in treatment structure. In many programs which serve alcoholics, antabuse may be the primary treatment provided, along with the legal minimum of one hour of therapy per week. Many programs provide no ongoing group therapy and few activities. Patients often loiter around the unit looking for something to do. If alcohol dependency is, in fact, the symptom of a psychopathological problem, then treatment must provide for this. While it is necessary to first arrest the physical dependency with detoxification or deterrent drugs in an alcohol free environment, a very intense program of psychological support must follow in order for treatment to be complete. In addition, substitute activities, reinforcement and gratification must be provided to make an adequate alternative to the alcohol dependent life.

If it is true that alcohol dependents and schizophrenics suffer similar kinds and degrees of psychopathology, it may follow that alcohol dependency is one among many possible symptoms of a basic psychodynamic disturbance, rather than a valid primary diagnosis. Obviously, more research needs to be done in this area before specific conclusions may be drawn and appropriate intervention assessed and applied.

CHAPTER VII

CONCLUSIONS

It has been the author's contention that alcohol dependency is often treated as the primary problem when, in fact, it should often be recognized as a symptom of isolation and deeper psychopathology. To some extent, the results of this study serve to support this hypothesis. By implication, this study supports the necessity for all therapeutic modalities to separate symptoms from their causes, and consequently to provide appropriate treatment for individual patients, according to their individual diagnostic needs.

Alcohol dependents, in particular, must have medical and psychiatric services which meet their underlying needs. While the toxic effects and reactions of alcohol must be a primary focus of early treatment, in order to ameliorate the alcoholic process (both physiologically and psychologically), more intensive psychotherapeutic intervention seems to be indicated as a means of attacking the underlying causal factors. In addition, emotional support must be focused on the acquisition and maintenance of socially acceptable and appropriate behavior patterns which satisfy

intrapsychic needs, and which will permit the addict to achieve some measure of self-esteem and success within his or her society. According to Alcoholics Anonymous (1974) it is imperative that substitute structures be provided for the alcoholic after discharge, such as meetings and activity clubs.

This study has demonstrated the value of the diagnostic applicability of art productions in research, and in analysis of clinical data. More research, under controlled conditions, with patient groups and a well planned research design, would be of value in attempting to standardize and improve the quantification of art therapy diagnostic evaluations.

In the context of the field of alcohol abuse, there is tremendous potential for further study and research into the psychodynamics of abuse and addition, and of the many applications of various therapeutic modalities to the addicted person. It has been the author's experience that many alcoholics who return to previous jobs, peers, and functioning revert to their pathological behavior readily. Therefore emotional and societal supports are necessary to provide alternative social structures for the alcohol dependent.

Further explorations in these areas will add immeasurably to the knowledge and reliability of Art Therapy and its applicability to diagnosis and treatment of alcohol abuse and addiction.

BIBLIOGRAPHIES

"Alcohol, Drugs, and Personality," G. W. Mercer Addiction Research Foundation, Toronto, Canada, 1970.

Alcoholics Anonymous, Alcoholics Anonymous, Alcoholics Anonymous World Services Inc., N. Y. 1974.

Anastasi, Anne and Foley, Joseph Jr. "An Experimental Study of the Drawing Behavior of Adult Psychotics in Comparison with that of a Normal Control Group," Journal of Experimental Psychology, Vol. 34, No. 3, June, 1944.

Andreoli, Vittorino M. and Nereo, Saglia. "Graphic Expression in a Rehabilitated Schizophrenic," Art and Psychotherapy, Excerpta Medica Foundation, Amsterdam, 1969.

Arieti, Silvana. "The Meeting of the Inner and External World: In Schizophrenics, Every Day Life, and Creativity," American Journal of Psychoanalysis, Vol. 29, No. 2, 1969.

Bellwood, Lester. "Grief Work in Alcoholic Treatment," Alcohol World: Health and Research, 1975, Experimental Issue.

Blane, Howard T. "A Procedure for Establishing Contact with the Alcoholic," Quarterly Journal of Studies on Alcoholism, 1961, 22:325-328.

Blane, Howard T., Chafetz, Morris, and Hill, Jorie. Frontiers on Alcoholism, Science House, N. Y. 1970.

Blum, Richard. Resource Book for Drug Abuse Education. U. S. Department of Health Education and Welfare, Public Health Service, Chevy Chase, Md., 1969.

Born, Wolfgang. "Art and Mental Disease," Ciba Symposia, 1946, 7:202-207.

Brill, A. A. "Alcohol and the Individual," New York Medical Journal, 1919, 109-928-950.

Cameron, Dale C. and Associates. Manual on Alcoholism, American Medical Association Publishing, Chicago, Ill., 1968.

Cantanzaro, Ronald. Alcoholism: The Total Treatment Approach, Alcohol Press, New Haven, Conn., 1961.

Chafetz, N. E. "Practical and Theoretical Consideration in the Psychotherapy of Alcoholism," Quarterly Journal of Studies on Alcoholism, 1959, 20:281-291.

Dagyalu, Kazirn, Koptagel, Gunsel and Veliogu, Suleyman. "The Development of the Psychopathological Process in the case of Schizophrenics as Observed from his Writings and Drawings," Art and Psychopathology, Vol. 31, No. 1, 1957.

Davidson, Gerson M. and Wise, Beatrice Vorhause. "Some Observations on Art and Psychotherapy with Reference to Schizophrenia," Psychiatric Quarterly Supplement, 1958, 31-222-238.

Day, Johanna and Kwiathowska, Hanna V. "The Psychiatric Patient and his 'Well' Sibling," Bulletin of Art Therapy, 1962.

DeWitt, William A. Drinking, Grossett and Dunlap, N. Y. 1952.

Eckhardt, Marianna. "The Detached Person," American Journal of Psychoanalysis, 1960, 20:139-149.

Eissler, K. R. "On Isolation," Psychoanalytic Study of the Child, 1959.

Fenichel, O. The Psychoanalytic Theory of Neurosis, Routledge and Regan Paul, London, 1946.

Fenichel, Otto. "On Isolation," Collected Papers, 1928, 1:147-152.

Forrest, Grace. "The Problems of Dependency and the Value of of Art Therapy as a Means of Treating Alcoholism," Art Psychotherapy. 1975, 2:15-43.

Freud, A. The Ego and Mechanism of Defense, International Universities Press, N. Y. 1960.

Freud, S. The Standard Edition of Complete Psychological Works, Hogarth Press, London, 1966.

Freud, Sigmund. "Three Contributions to the Theory of Sex," (4th Edition; Washington, D. C. Nervous and Mental Disease, Publishing House, 1930).

Glover, E. "The Etiology of Addiction," International Journal of Psychoanalysis, 1932, 13:298-328.

Griffith, Edward. "Drugs, Dependency and Plasticity," Quarterly Journal of Studies on Alcoholism, 1974, 35:176-195.

Hoffe, Ebbe Curtis. New Concept on Alcoholism, Alcohol Press, New Haven, Conn. 1961.

Ihsan, Ahsel S. Koptagel, Gunsel, Elbirlih, K., Wharton, J. "A Comparative Study of the Distortion of Proportion in Normal and Schizophrenic Art," Art and Psychotherapy. Excerpta Medica Foundation, Amsterdam, 1969.

Jakob, Irene. "Art and Insanity," Medical Opinion, 1972,8:3.

Jellinek, E. M. Disease Concept of Alcoholism, College Press, New Haven, Conn. 1960.

Jones, E. "Papers on Psychoneurosis," (Baltimore: Ward and Co., 1938).

Kalant, H. Newer concepts on Alcoholism, Alcohol Press, New Haven, Conn. 1961.

Knight, R. P. "The Psychodynamics of Chronic Alcoholism," Journal of Neurosis and Mental Disease, 1975, 86:538-545.

Kolb, Lawrence C. Modern Clinical Psychiatry, 8th Edition, W. B. Saunders and Co., Philadelphia, Pa., 1973.

LaForque, Rene. "The Mechanism of Isolation in Neurosis and its Relation to Schizophrenia," International Journal of Psychoanalysis, 1929. 10: 170-182.

Levick, Myra; "Art Therapy - Diagnostic and Therapeutic Tool;" Art and Psychopathology; Excerpta Medica Foundation, Amsterdam, 1969.

Machover, Karen. Personality Projection, Charles C. Thomas, Springfield, Ill. 1961.

Marinaw, A. "Mental Illness as Reflected in Machover's Drawing Test," Art Interpretation and Art Therapy (ed. by I. Jakob) Psychiatry and Art, Vol. 2, Fifth International Colloquium of the Psychopathology of Expression, Karger, Basel, 1971.

McClelland, David C., Davis, William, Kalin, Rudolph, Wanner, Eric., The Drinking Man, Free Press, N. Y. 1972.

Menninger, K. A. Man Against Himself, Harcourt-Brace, N. Y., 1938.

Naumberg, Margaret. Psychoneurotic Art: Its Function in Psychotherapy, Grune and Stratton, N. Y. 1950.

Naumberg, Margaret. Schizophrenic Art: Its Meaning in Psychotherapy, Grune and Stratton, N.Y. 1950

Ohlmeier, Dieter and Hinrich, Crauner. "Representation of Himself and of Those Close to Him in a Series of Pictures by a Young Schizophrenic," Art and Psychopathology, Excerpta Media Foundation, Amsterdam, 1969.

Pickford, R. W. Studies in Psychiatric Art, Charles Thomas, Springfield, Ill. 1967.

Plokker, J. H. Art for the Mentally Disturbed, Little, Brown, and Co., Boston, Mass. 1965.

Rado, S. "The Psychoanalysis of Pharmacothymia," Psychoanalytic Quarterly, 1933, 2:1-23.

Rappaport, C. The Collected Papers, Morton Gill Co., N. Y. 1967.

"Rehabilitation in Alcoholism," U. S. Department of Mental Health; Public Health Service, Bethesda, Md., 1963.

Reitman, Francis. Psychotic Art, Routledge and Regan Paul, Ltd. London, 1950.

"Report on Alcoholism," World Health Organization, Expert Committee on Mental Health, Alcohol Subcommittee, 2nd report, No. 48.

Ritson, Bruce and Hassall, Christine, The Management of Alcoholism, Livingston Co., London, 1970.

Schilder, P. F. "Psychogenesis of Alcoholism," Quarterly Journal of Studies on Alcoholism, 1941, 2:227-229.

Simon, Rita. "Art Therapy at a Crisis of Psychotic Confusion," Art and Psychopathology, Excerpta Medica Foundation, Amsterdam, 1969.

Sjoback, Hans. Psychoanalytic Theory of Defensive Processes, Halsted Press, N. Y. 1973.

Soloman, Philip and Patch,Vernon B., Handbook of Psychiatry, 2nd Edition, Lange Medical Publications, Los Altos, 1971.

Sperling, E. "On Denial and the Essential Nature of Defense," International Journal of Psychoanalysis, 1958.

Spitz, R. A. "Some Early Prototypes of Ego Defenses," Journal of American Psychoanalytic Association, 1961.

Volmat, R. "Art et Psychiatre," Psychiatric der Gegenwart, 1960, 3:3-10.

Waelder, R. Basic Theory of Psychoanalysis, International Universities Press, N. Y. 1960.

Wallerstein, E. S. "Development of Defensive Organization of the Ego," Panel Report, Journal of American Psychoanalytic Association, 1967.

Zimmerman, J. "Art Productions of Adult Psychotic," Psychiatric Quarterly, 1942, 16:313-318.

APPENDIX A: DEFINITIONS OF TERMINOLOGY USED IN THE ART THERAPY EVALUATION TEST RATING SCALE*

1. Fragmentation or disorganization:

Gross disorganization in the picture. Images are scattered over the paper with no apparent relationship between them. If there is an association between parts they lack the concept of purpose. An example of this may be a picture containing a head, fruit, parts of an animal or person scattered helter-skelter over the page. When asked, the patient denies any connection between images. This is a reflection of ego disintegration and may be symptomatic of schizophrenia.

2. Splitting:

A division of the picture into two sections, either horizontally or vertically. This can be accomplished by drawing a dividing line or separating the two parts by an empty space. The two parts may be divided by using a different style or manner in each. For example, in drawing a head one side of the face may be drawn in bright colors with a cheerful expression while the other side may be in dark

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colors and with a depressed expression. Splitting most often occurs in the schizophrenic group of illnesses.

3. Confusion:

This is shown by a series of disturbed, bewildered, mixed-up forms, shapes, lines or colors from which it is difficult to make any logical sense. This represents a disturbance in the sense of awareness of time, place, or person and may be caused by organic or psychological disturbances.

4. Unbalanced use of space:

This consists of an inharmonious arrangement of forms, unequal distribution of pictorial elements, or a disequilibrium in arrangement of images on the paper. An example of this may be a picture drawn in one corner of the page only. It is most frequently seen in toxic psychosis (drugs) or schizophrenia.

5. Orality:

The earliest stage of psychosexual development is divided into two phases oral erotic and oral sadistic. The first is related to the pleasures of sucking and the second is associated with biting. Blocking of oral needs leads to conflicts which show themselves in pictures centering around food, round openings, mouths, holes, attachments between objects, objects within colors, shapes enveloped by other shapes or lines.

6. Flatness of affect:

This is shown by a general impoverishment of emotional tone of the picture, or a feeling of blankness, dullness, or uninvolvement conveyed by the picture. It can appear in landscapes, portrayals of people, or abstract drawings. It is rarely seen outside the schizophrenic group of illnesses.

7. Primitiveness:

According to Fenichel, "primitivation" is a regression of the ego to the early primitive stage in its development where "objective thinking is replaced by magical or wish-fulfillment thinking, object relations are of the passive dependent type or totally lacking, and sexuality is on the oral erotic level." (Hinsie & Campbell, 1970). In patient's art work, it is generally depicted by an overall childlike quality, and an infantile manner of describing the world. For example, people may be drawn as stick figures and there may be a preoccupation with magical objects or a depiction of wish-fulfilling fantasies (devils, angels, etc.). Primitiveness may occur in both traumatic neuroses and schizophrenia.

8. Symbiosis:

The inability to attain a separate identity is shown in pictures by lines or shapes connecting significant people to one another. This can be in the form of a collar or leash, rope or umbilical cord, or by undifferentiated boundaries between people. One figure may seem to have grown

out of another, or may overlap another. This is most often associated with schizophrenia.

9. Distortion of body image:

A gross disturbance of body image is shown by exaggerated, missing or misplaced parts. This disturbance appears most often in the schizophrenic groups.

10. Transparency:

Objects or parts of objects are visible through other objects. In figures, the internal organs may be visible as well as the exterior shape. A frequently seen example is that of the uterus with fetus contained within the outlines of the figure. This disturbance appears most frequently in schizophrenia.

11. Persecutory figures or objects:

The psychoanalytical term, ideas of reference, refers to "incorrect interpretations of casual incidents and external events as having direct reference to oneself." (Hinsie & Campbell, 1970). With sufficient intensity this suspiciousness may take on delusionary proportions. This is reflected in patient's art work by the presence of suspicious or threatening figures, objects, or parts of the body. For example, the picture may contain many eyes, or there may be an exaggeration of the size or shape of the eyes. The patient may picture a person surrounded by other people who are looking at him in a hostile or accusing way. This may

be an indication of paranoid schizophrenia.

12. Diffuseness:

This refers to an inability to condense and contain separateness of objects. It is reflected in images by undefined ego boundaries shown through indefinite shapes, lack of outlines, merging of shapes into one another, or fuzziness. It may be an indication of schizophrenia.

13. Concreteness:

This is a literal representation of thoughts and feelings which represent the antithesis of abstraction. It shows an inability to draw abstract conclusions from events and experiences. This may be shown in pictures by labels naming parts of the picture, such as, "sky," "house," "grass," etc. It is one of the elements in primary process thinking and is most often an indication of schizophrenia.

14. Images showing estrangement from self or surroundings:

This is an indication of the process of dissolution of the identity and is referred to in psychoanalysis as depersonalization. It is characterized by "loss of the sense of reality of oneself, others, and the environment." (Hinsie & Campbell, 1970). Patients may show this by drawing eery or unreal landscapes, dream-like environments, skeletal distorted figures. An example of this may be a picture of a vast desert containing a dismembered body. End of the world fantasies are also commonly depicted. It is present to

some degree for short periods of time in all formal diagnostic groups but may be complete and lasting in schizophrenia.

15. Flight of ideas:

This is portrayed in images of many different thoughts and ideas, all of them incomplete or fragmentary, but arranged in logical sequence on the paper. It is characterized by short jumps in logic between sequences of thoughts or ideas. This is symptomatic of acute manic states.

16. Other expressions of mania:

The manic states are portrayed in visual images by excesses in line, color, or form, such as vivid colors, excessive motion, boldness of line, and ebuillient or wild affect. These may be present with or without a flight of ideas.

17. Expressions of depression:

Depression may be indicated by the use of a preponderance of dark colors, particularly black, and by the frequent portrayal of boxes, box-like shapes, or boxes within boxes. Direct portrayals of depressed-looking people are also frequently drawn. Signs of depression can be exhibited by all formal diagnostic groups, with the exception of manic states.

18. Suicidal imagery:

This consists of images depicting various direct or indirect ways of doing away with oneself. For example, the

picture may show a person jumping out of a window or merely show a person standing on the edge of a window about to jump. It appears in all formal diagnostic groups except manic states.

19. Expressions of aggression:

Sharp or pointed shapes, objects thrusting forward, images depicting violent scenes, and the predominant use of violent and strong colors are used by patients who are experiencing a pathological intensification of feelings of hostility and aggression. May appear in all formal diagnostic groups.

20. Isolation:

The psychoanalytical definition of this term is "the separation of an idea or memory from its affective source leading to an impoverishment of stimulus and response." (Am. Psych. Assoc., 1967). It is shown in patient's art work by figures, forms or symbols which are set apart from the environment or placed alone on the paper. For example, a tiny figure may be placed in a vast, overpowering landscape, or be surrounded by blank paper. This can appear in all formal diagnostic groups but is most commonly a defense in obsessive-compulsive disorders.

21. Symbolization:

A symbol is an object that stands for or represents something else. It is usually a condensation of forbidden

feelings and conflicts which become fused and remain in the unconscious in the form of concrete representations of abstract thoughts and feelings. Such indirect representations may appear as pictures of hallucinations, compulsions, obsessions, dreams, etc. The use of symbols by a patient may indicate psychosis but is also present in neurotic illness, anxieties and hysteria.

22. Expressions of denial:

In psychoanalysis denial is defined as "a defense mechanism of a primitive variety, in which the ego refuses to become aware of some painful aspect of reality." (Hinsie & Campbell, 1970). The patient "dissociates" himself from the painful facts. Patients sometimes dissociate themselves from the picture itself, denying any knowledge of it, thus separating themselves from the ideas, situations, or objects shown in the picture, as if it were drawn by someone else.

23. Denial of aggression is also shown by eliminating significant parts of the body which may be capable of aggressive acts, such as hands or feet. The patient may leave out eyes or ears to indicate his refusal to see or hear painful aspects of reality. Dissociative reactions and degrees of denial can be seen in all diagnostic categories.

24. Messages:

Relevant or irrelevant messages are sometimes written on pictures. These pertain to content and may either

contribute to an understanding of the picture or cause confusion in the observer. For example, the message may say "help," or "let me out of here" or may consist of lists of names or numbers. These differ from the labelling of objects used by psychotic patients. Messages are used by both psychotic and neurotic patients to varying degrees.

25. Ambivalence:

The coexistence of simultaneous, opposing drives, desires, or feelings is portrayed in pictures by more than one set of tumultous lines, forms, or colors. Each set is given equal importance in the picture. A feeling is conveyed that the patient cannot make up his mind as to which is more important. They are at times contradictory. Ambivalence is evident to some degree in both neurotic and psychotic art work.

26. Turbulance:

Lines, colors, or forms drawn in an agitated, disorderly fashion. The picture conveys a feeling of agitation and turmoil to the viewer. This is a neurotic manifestation of conflict and anxiety.

27. Repetition:

The repeated use of a symbol, i.e. animal, bird, tree, geometric shape, etc., to represent self or object, or a variety of symbols, which represent an idea or association with which the patient is preoccupied. This appears most

frequently in the work of obsessive-compulsive patients, but may be used in varying degrees by neurotics and psychotics.

28. Geometric designs:

As a defense against anxiety, patients frequently make geometric designs which grow out of one another in picture puzzle fashion. This is used as an obsessive-compulsive defense in varying degrees by both neurotics and psychotics.

29. Excessive detail:

After drawing gross forms the patient may become caught up in elaborating minor details. He may draw in every leaf on a tree, or every blade of grass, etc. This is most frequently associated with neurotics using obsessive-compulsive defenses.

30. Rigidity:

This is characterized by stiffness and rigidity in lines, forms, colors and composition. There is a feeling of tightness and a lack of free-flow. As an indication of anxiety, this is most frequently associated with obsessive-compulsive neurosis.

31. - 33. Intensity of line or color:

The amount of pressure the patient applies to the paper is a frequent indication of the degree of anxiety. Patients who are feeling insecure and lacking in self-confidence often draw very faint lines, while patients who

are feeling intense anxiety apply strong pressure to the paper. 31 - 33 should be rated as follows:

(1) slight pressure

(2) average pressure

(3) strong pressure

34. Erasures:

Erasures are seen as an indication of conflict and anxiety. Patients frequently erase objects or parts of the body about which they feel the most conflict. This may be used by patients in all diagnostic categories.

35. Incompleteness:

Important gross forms or significant details are left out of the picture. This may be associated with all diagnostic categories to some degree.

36. - 38. Discrepancies:

Perceptual distortions are revealed by the incorrect reproduction of life objects. Discrepancies in reality testing can exist in form, color, or detail. This is associated with all diagnostic categories to some degree.

39. - 41. Mistakes:

The addition of extra lines, colors, or shapes which are not perceived, erased, or otherwise corrected are classified as mistakes. Disturbances in reality testing, such as this, can be associated with all diagnostic categories to some degree.

42. Perseveration:

According to Webster's Dictionary, to perseverate is to continue doing something in spite of opposition or difficulty. Psychoanalysis defines perseveration as the involuntary persistence of a single idea or response. This appears most often in cases of organic brain disease, although it may be seen in schizophrenia. Perseveration appears in art work by a constant, repetitious use of the same type of line or shape, over and over again, on the paper. This may be in the form of swirls, dots, broken lines, etc. In scribble drawings patients often seem to be making perseverated lines, although this is not an indication that the disturbance is of an organic nature.

43. Inability to make or complete geometric shapes:

An outstanding sign of organicity in art work is an inability to make geometric shapes or to connect lines which were meant to meet. For example, in making a circle the patient will leave a space between the beginning and end of the circular line, or broken spaces will be left between the four lines which make up a square.

44. Unsteady or shaky lines:

Lines which are trembling, shaky or interrupted with frequent breaks may be an indication of organicity.

45. Reversal:

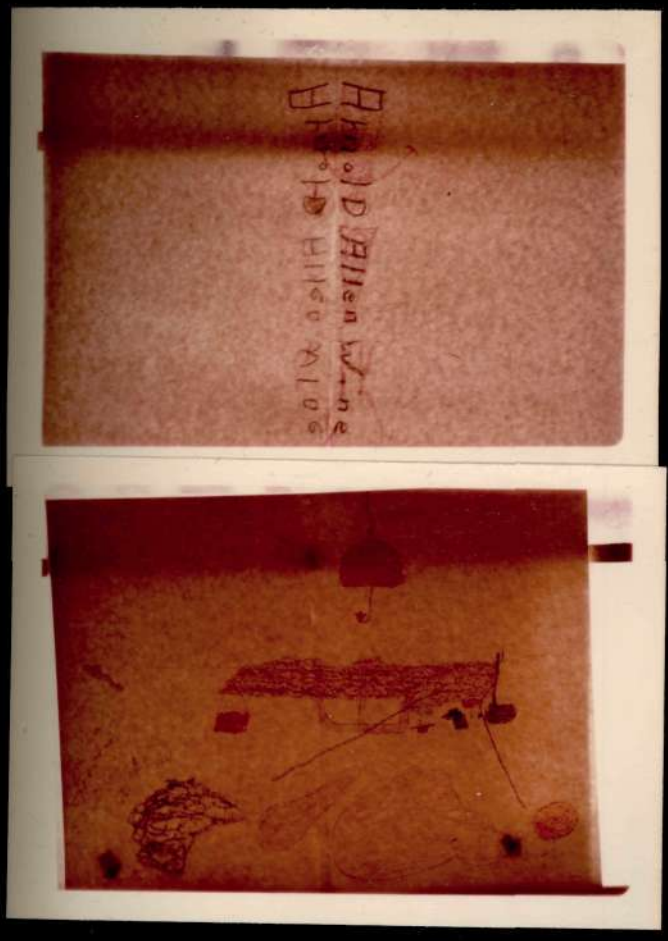
Organic patients frequently reverse or make mirror

images of what they see. For example, a head seen in left profile may be drawn in right profile or objects which should point up are drawn pointing downward, etc.

46. Spaces between related objects:

Organic patients frequently leave spaces between related objects which were meant to touch. An example of this is a cup and saucer which may be drawn with a space between them.

Appendix B



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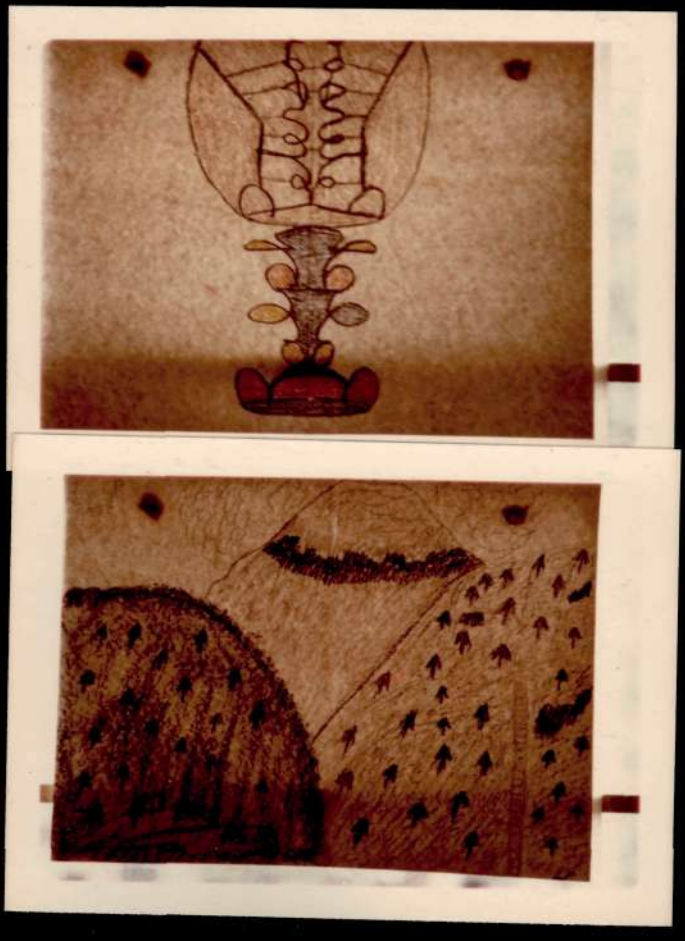

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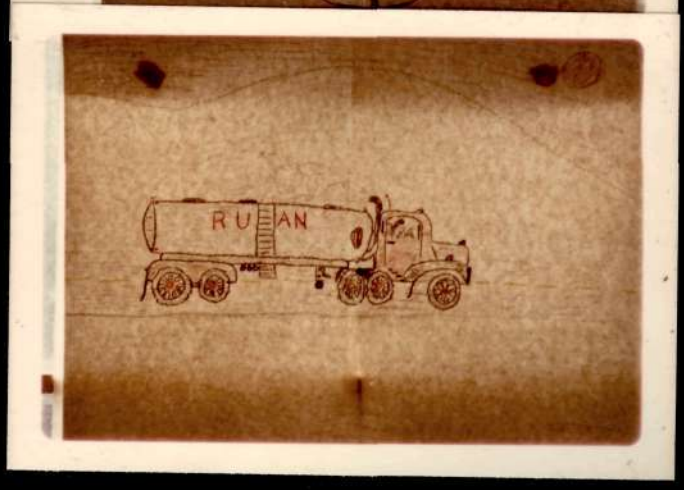

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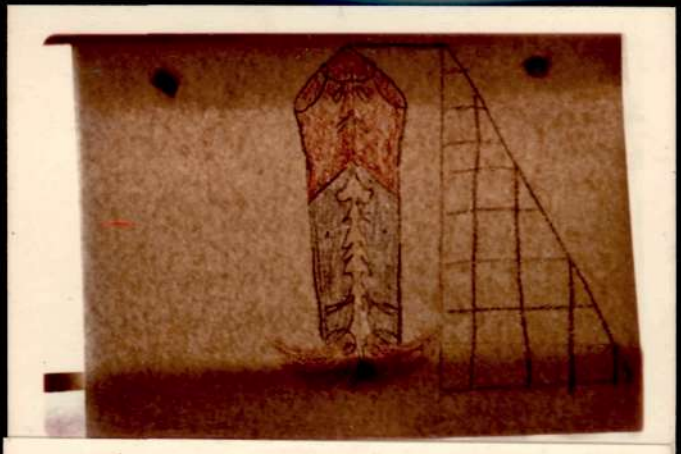

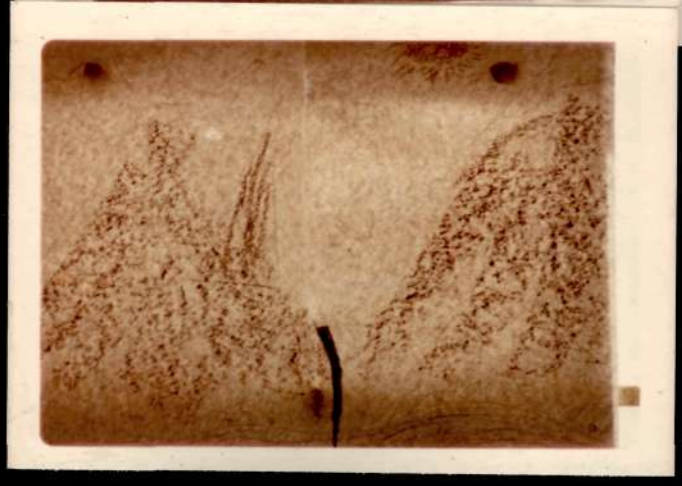

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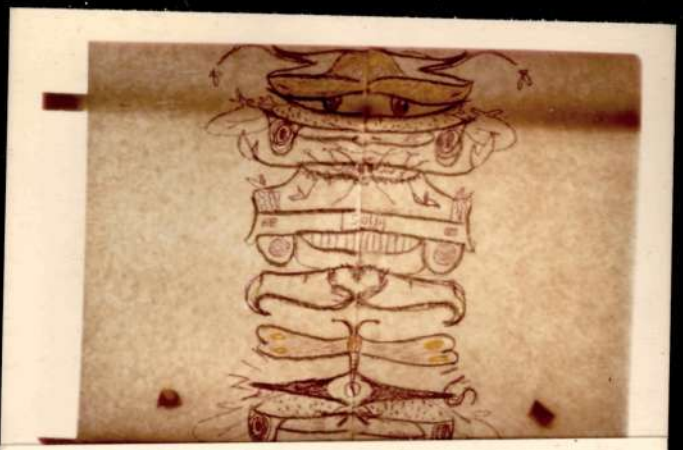

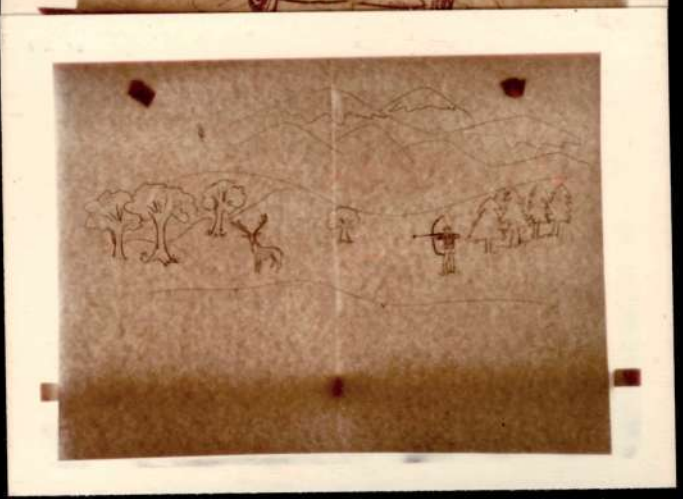

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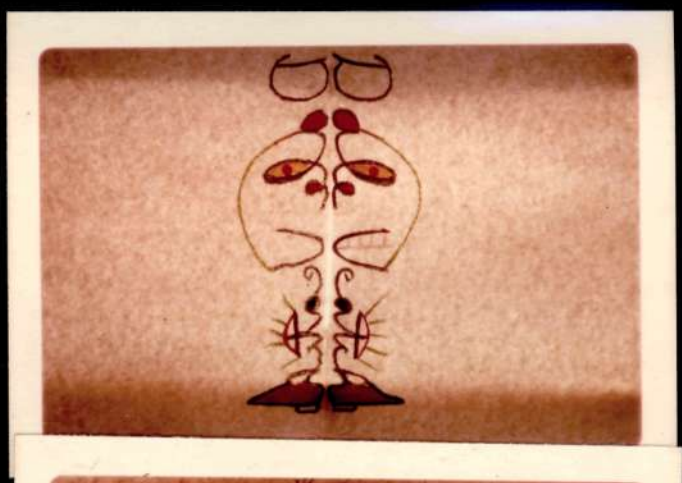

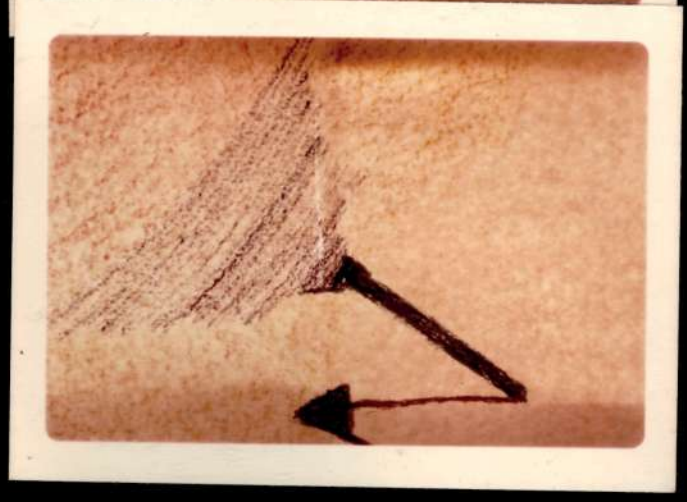

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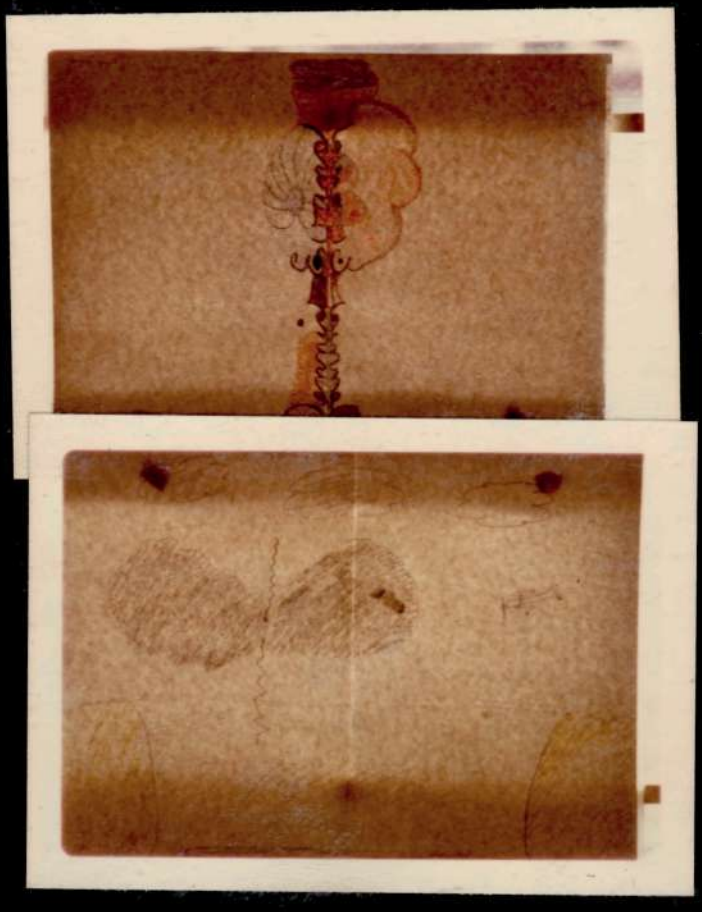

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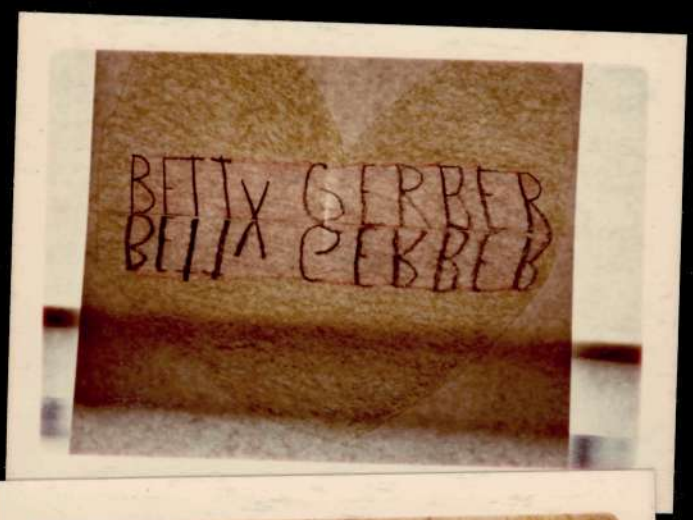

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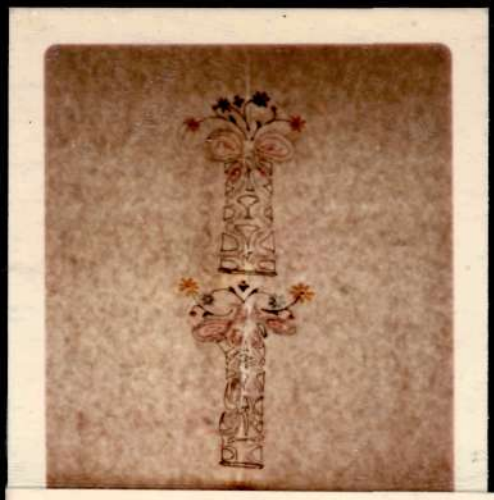

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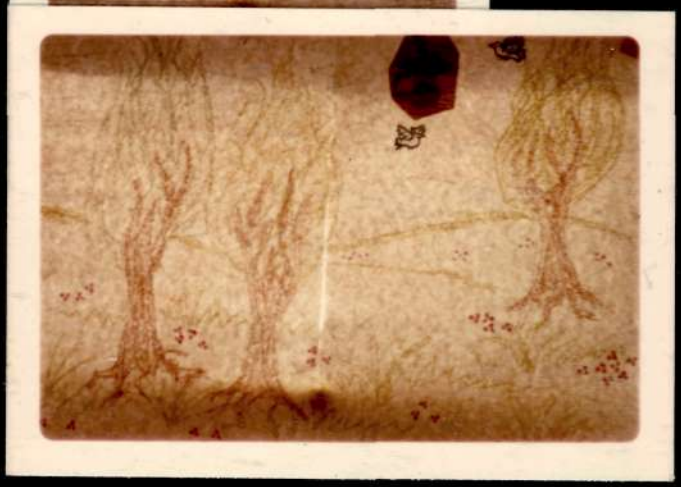

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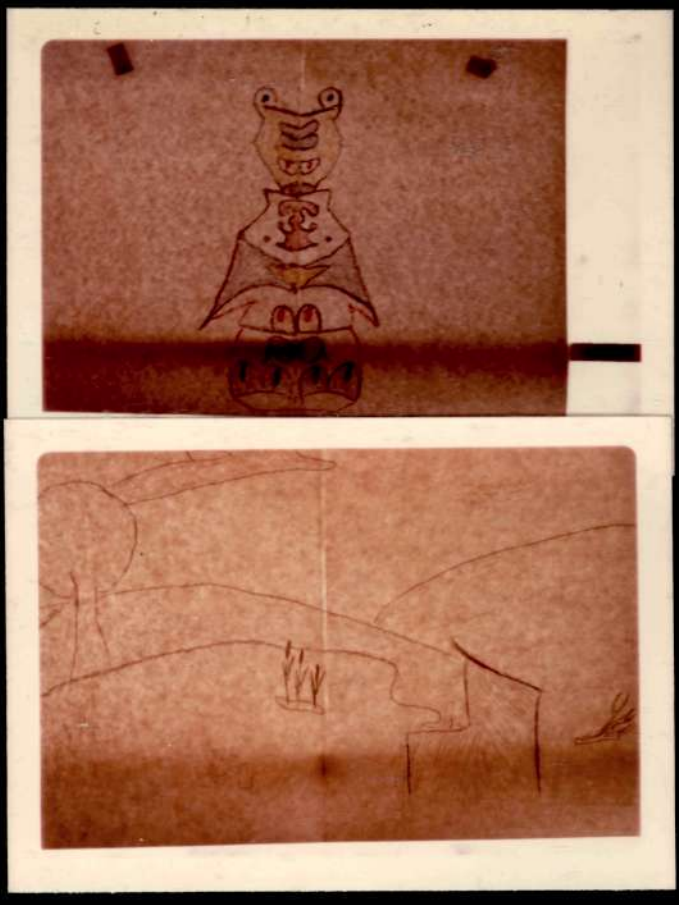

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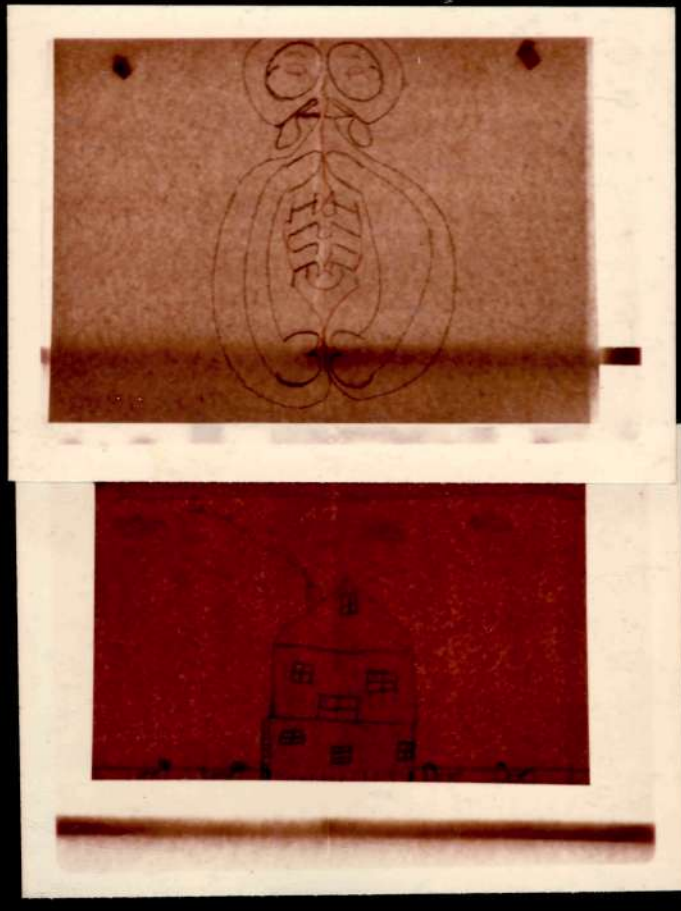

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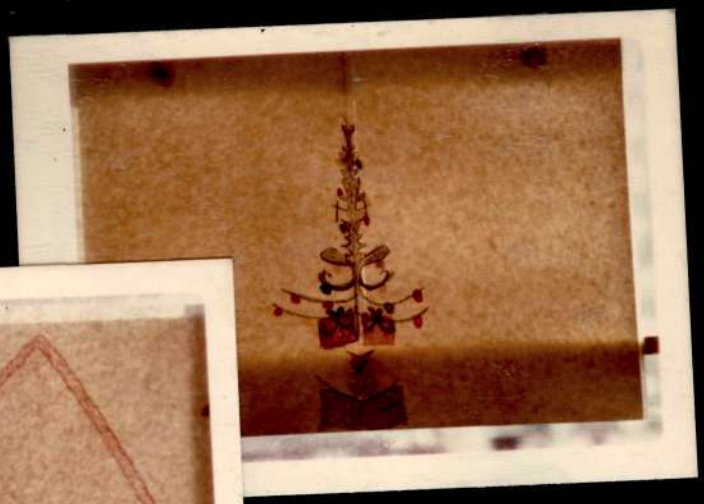

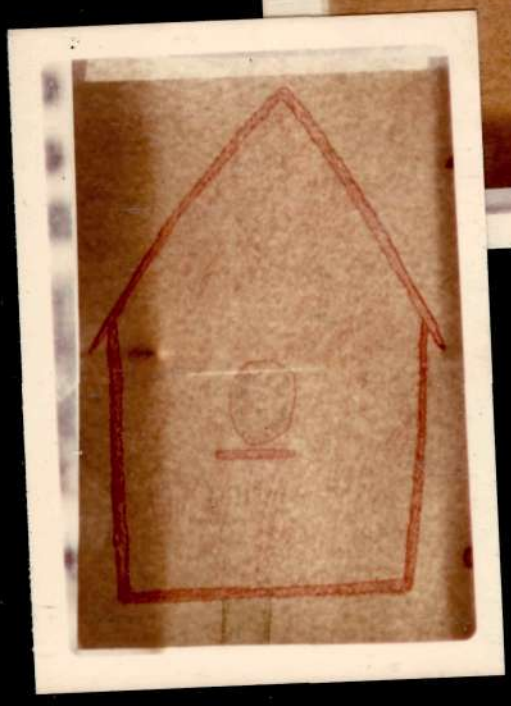

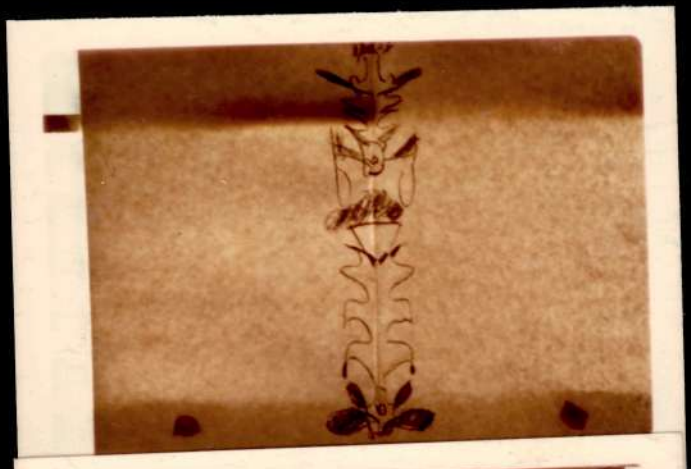

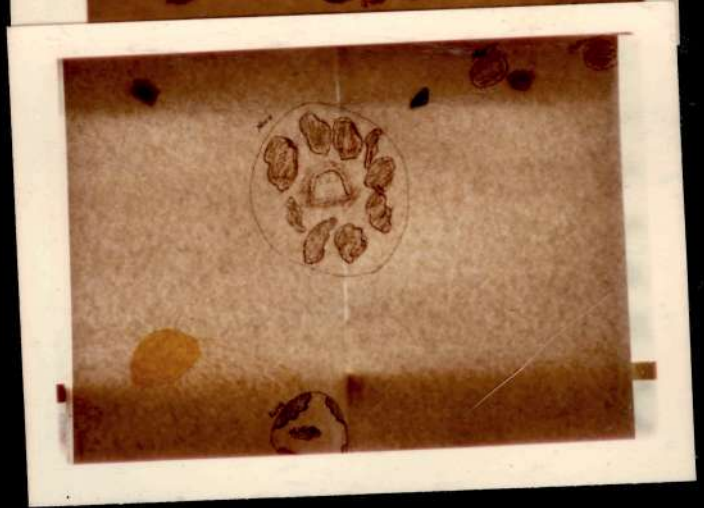

ADDENDUM

RESULTS OF T-TEST ON ASPECTS OF EGO DISTURBANCE = .037 NO SIGNIFICANCE

FIGURE 2

RATING RESULTS

Alcoholics		Schizophrenics	
S_1	35	S_{11}	26
S_2	30	S_{12}	34
S_3	12	S_{13}	26
S_4	34	S_{14}	22
S_5	28	S_{15}	25
S_6	29	S_{16}	26
S_7	25	S_{17}	27
S_8	25	S_{18}	25
S_9	24	S_{19}	18
S_{10}	25	S_{20}	24

ADDENDUM

RESULTS OF T-TEST ON CONFLICT AND ANXIETY = 1.85 NO SIGNIFICANCE

FIGURE 3

RATING RESULTS

Alcoholics		Schizophrenics	
S_1	22	S_{11}	15
S_2	24	S_{12}	11
S_3	12	S_{13}	14
S_4	16	S_{14}	14
S_5	11	S_{15}	15
S_6	11	S_{16}	18
S_7	16	S_{17}	9
S_8	12	S_{18}	8
S_9	13	S_{19}	6
S_{10}	11	S_{20}	6

ADDENDUM

RESULTS OF T-TEST ON REALITY
ORIENTATION = .240 NO SIGNIFICANCE

FIGURE 4

RATING RESULTS

Alcoholics		Schizophrenics	
S_1	0	S_{11}	0
S_2	2	S_{12}	2
S_3	1	S_{13}	0
S_4	0	S_{14}	0
S_5	1	S_{15}	0
S_6	0	S_{16}	0
S_7	2	S_{17}	2
S_8	1	S_{18}	2
S_9	1	S_{19}	0
S_{10}	0	S_{20}	3

ADDENDUM

RESULTS OF T-TEST ON ORGANICITY = 0
NO SIGNIFICANCE

FIGURE 5

RATING RESULTS

Alcoholics		Schizophrenics	
S_1	5	S_{11}	0
S_2	4	S_{12}	0
S_3	0	S_{13}	0
S_4	0	S_{14}	0
S_5	0	S_{15}	0
S_6	0	S_{16}	0
S_7	0	S_{17}	0
S_8	0	S_{18}	0
S_9	0	S_{19}	0
S_{10}	0	S_{20}	0

ADDENDUM

RESULTS OF T-TEST ON ISOLATION = 1.85
NO SIGNIFICANCE

FIGURE 6

RATING RESULTS

Alcoholics		Schizophrenics	
S_1	2	S_{11}	5
S_2	4	S_{12}	4
S_3	3	S_{13}	3
S_4	6	S_{14}	4
S_5	3	S_{15}	4
S_6	4	S_{16}	4
S_7	3	S_{17}	2
S_8	5	S_{18}	3
S_9	3	S_{19}	4
S_{10}	2	S_{20}	4

ADDENDUM

FIGURE 7

TABLE OF T-TEST SCORES

Aspects of ego disturbance	t = .037
Aspects of conflict and anxiety	t =1.85
Reality Orientation	t = .240
Organicity	t = 0
Isolation	t =1.85

Levels of significance ... .05 = 2.101
.01 = 2.878